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WHO IS MENTALLY HEALTHY?

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'I have read every definition of insanity which I could meet with, and never was satisfied with one of them, and I have endeavoured in vain to make one satisfactory to myself. I verily believe it is not in human power to do it.'
Lord Blackburn

An interesting and important phenomenon has been taking place almost unnoticed in our midst for some years. We have been classifying certain modes of human behaviour as mental illness which have never been regarded in this way before. We all accept, of course, that the hallucinated and deluded schizophrenic person is ill. It remains, however, an open question whether that person is sick who is merely unhappy, since unhappiness is as essential a condition of life as the beating of the heart. Likewise, is it correct to say that the criminal needs medical attention for the cure of his antisocial behaviour, or that if a person's conduct does not conform to commonly accepted norms in the community, he should see a psychiatrist?

"We're sick", said a very eminent psychiatrist at a symposium which took place within the august walls of the Royal College of Medicine, 'We are all so damn sick'. Whether one agrees with him or not, and it is the purpose of this article to argue this, we must acknowledge that one way and another the incumbency of health, and especially mental health, has increased enormously and now includes many aspects of the human condition that previously belonged elsewhere. There are several reasons for this. To some extent it is a reflection of the difficulty that science and society have had in dealing with certain human responses in any other way. Ever since modern psychology demonstrated the physiological basis of behaviour, that is, that all behaviour, normal and abnormal, social and antisocial, moral and immoral, is as much a product of biological processes and metabolism as heart disease, desperate eyes have been cast in the direction of psychiatry — its medical and executive arm seeking help to bend human nature into the particular patterns that are desired. It is precisely because of this that psychiatry can easily be confused with other systems of values which guide or control people — the law, religion, morals, etc. In any case, people are used to presenting their discomforts to the doctors for relief, and there is an intrinsic hope (and sometimes a misplaced confidence) that doctors can heal them of their behaviour too. They may even go beyond this, and endow the doctors with a sort of god-like power. Psychiatry then takes the place of a religion — its teachings become a gospel and its practitioners the ministers thereof. Or, and this is by no means an uncommon expectation in the deeper and more secret layers of the mind, psychiatrists become imbued with magical powers to defeat nature and stay disease in its course.

The Scope of Psychiatry

The result of all this is that the scope of psychiatry has been vastly extended beyond that of well-defined mental disorder. The psychiatrist is now consulted in every conceivable personal or emotional crisis where experience becomes too much to bear — by one or both parties in a pending divorce action, where each may seek to prove that the other is unreasonable or 'neurotic' or is doing harm to the children; after a family argument; an unsatisfactory love affair; by people in trouble with the law; where a difficult personal decision must be taken; even in international affairs.

The training and knowledge of the psychiatrist have not usually equipped him to deal with these problems, although he may, nevertheless, feel it his duty to do what he can. For one thing, he is usually in posession of a fine medical conscience, the result of years of training in a profession where humanistic considerations and the need to relieve suffering override all other considerations. In addition, there is a certain flattery in being asked to solve some of life's problems where others have failed.

There is, however, enormous frustration in trying to remedy something medically that is fundamentally moral, social, cultural, or even political. Psychiatry is a healing art, engendered by psychology, practised on the model of clinical medicine, and oriented in a therapeutic direction. Its notions are not necessarily apposite when divorced from this frame of reference and cannot be applied to other situations with impunity. To some extent too, it is a matter of humility. Because the psychiatrist knows something about mental illness and the inner workings of people's minds, he is not necessarily an expert on all human affairs, and should deny the temptation to treat them as he would illness. Curran,[1] in a cry from the heart, inveighs against this 'expansionism' of psychiatry, pointing out that there is danger of falling into the fallacy that because a problem has psychiatric facets it must necessarily be regarded as a purely psychiatric affair.

The Meaning of Psychiatry

A great deal of the difficulty that arises lies in conceptualizing what psychiatry is. As Szasz[2] points out,

psychiatry is regarded by some as being the study of diseases of the brain with close affinities to the subject of pathology; by others as the study of diseases of the mind (the concept of 'mind' is capable of very wide variation and adds further confusion); and by still others as that branch of medicine which deals with disorders of behaviour. The latter view appears to simplify matters by minimizing unreliable subjective factors and taking account of only the observable functioning of the organism.

The confusion is reflected in the unsatisfactory state of psychiatric nosology. There is no unitary basis for the classification of mental illness and consequently the two most generally used systems, namely the 'International statistical classification of diseases, injuries and causes of death' of the World Health Organization, and the 'Diagnostic and statistical manual of mental disorders' of the American Psychiatric Association, although representing sincere attempts to provide standards to work by, are no more than a *mélange* of diverse conceptions. For example, the diagnosis of 'depersonalization', which is a subjective sensation, or a symptom rather than a disease, is considered together with the diagnosis of 'inadequate personality' — an assessment made on the adequacy of the person's response to life's circumstances; and 'chronic brain syndrome due to cerebral arteriosclerosis' — an organic disease of the brain.

The situation is further complicated by the fact that psychiatry, in common with other developing sciences, is burdened with 'explain-alls', words such as 'insanity', 'mental health', 'schizophrenia', 'psychopath', and 'psychosis', which words, although seeming to enlarge our understanding, really restrict it, because they cover so wide a field as to be meaningless unless heavily qualified. For instance, psychosis as defined according to the law and psychosis as defined in psychoanalytic terms are two very different things. Hardin[3] calls these words 'panchrestons', (coined from the analogy of panacea — a cure-all), and points out that they have the added disadvantage of stopping enquiry where it is more painful, difficult, and likely to fail by seeming to denote fixed, indivisible entities. These words are no more than seemingly valid, for they represent man-made epistemological categories rather than actual diseases. 'Schizophrenia' and 'psychopathy' are good examples of this because they comprise a variety of very dissimilar conditions, and the investigation of each as a thing-in-itself must therefore fail.

Mental Health

The same difficulties beset the definition of mental health, for it is certain that neither mental health nor its counterpart, mental illness, are absolute or ultimate entities, although as Eaton[4] observes, the public in general and the patient in particular keep up the fiction that they are. A patient with a mental problem wants to believe that whatever he suffers from has form and finiteness — a beginning and an end and, if possible, an accurate description in a textbook with detailed instructions for its successful treatment! In short, he wants to know that what affects him is understood and that psychiatry can definitely cure him. People look for finality (quick confident answers) and certainty in an uncertain world. Neat packaging leads us to believe that the thing can be easily handled, and a label reassures everyone by implying that we know all about it. The fact is, however, that oversimplification merely hinders understanding. The public are quite often unwittingly abetted in this by the psychiatrists themselves, whose training and the scientific tradition, very laudably perhaps, makes it important to categorize and label. Moreover, they are constantly being dunned for concrete help to relieve symptoms and emotional distress *now*. Psychiatrists need practical tools to work with and, if diagnosis means assuming certain conceptions to be valid, the attitude they often adopt is to get on with it and down to treatment!

WHAT IS MENTAL HEALTH?

What exactly is mental health then? Who is to be categorized as well and who insane; or, at least, whose mental processes are disordered, deviant, or disturbed, and whose merely an extreme within the range of normal? I propose to examine the matter of definition in some detail in an attempt to discover some answers to these questions.

The first conclusion to establish is that neither mental health nor its counterpart, mental illness, are absolute or unitary entities, or sharply demarcated from each other. There are many varieties of mental illness, and their number has increased greatly in recent years due, as we have already pointed out, to the inclusion of various patterns of behaviour or states of mind which previously were not included in the category of mental ill-health. Amongst these are conditions such as alcoholism, delinquency, homosexuality, absenteeism, accident proneness, drug addiction, and speech disturbances such as stammering, learning difficulties, etc. The basis of this regrouping is largely a matter of a general change in attitude to regard any major deviation from the norm as disease. Whether this is always justified is debatable. It would certainly be incorrect to classify naturally-occurring extremes of normal states, such as constitutional mental defect, as illness, since inborn intelligence ranges in the population from idiocy to genius. By the same token we would have to regard genius as illness. Similar reasoning would also lead us to dub all those under 5 feet in height as abnormal!

Another misconception which needs to be disclaimed is that the mentally-ill person is a different order of being, something less than human, to the rest of us. This is manifestly untrue. The mentally-ill person uses the same kinds of mental processes, although in a somewhat different way or with his own unique twist. He may for instance have an exaggerated reaction to a situation and distort reality to fit his own ideas and preconceptions, but the difference between his mental operations and behaviour and those of the non-psychotic person is primarily one of degree and not of kind. To give a commonplace example; a proper sense of one's own worth and an adequate feeling of self-regard are necessary for peace of mind and mental health. It is not a far cry from these to an overweaning sense of our own importance, and only a step from thence to feelings of omniscience and omnipotence, and to the crystallization of these into delusions of grandeur. In addition, there is no 'all or none' principle involved — the mentally-ill person is not necessarily ill in all parts of his personality; nor is he sick all the time.

Neither, of course, are 'normal' people always or completely healthy. All of us can be said to suffer an occasional touch of mental illness, for instance, when primitive material that is kept repressed in the unconscious mind emerges into awareness, during dreams or in our secret phantasies.

There is therefore not much point in trying to separate the sheep from the goats by regarding only those who present themselves for treatment for signs and symptoms of mental disorder, as ill. We know that there are innumerable people walking around, even doing a good day's work, who are grossly disordered, and it is being increasingly recognized that hospitalization has more to do with the patient's participation and functioning in his community than with purely medical considerations. This is borne out by the legal criteria laid down in most countries for certification of the mentally ill which specify that there must be reasons in addition to mental disorder, e.g. not only must the person be mentally disordered, but by reason of such disorder he must constitute a danger to himself or others, or need care and control. That is, it is ultimately his behaviour that conditions his being placed under the provisions of the law. Hollingshead and Redlich[5] describe the determinants for hospitalization as follows:

'The attitudes of the family towards its psychotic member are responsible to a significant degree for the determination of who goes to hospital, who stays home, who improves in hospital, who "deteriorates", and eventually stagnates in the chronic ward.'

'Patients are not discharged just because they are well, neither are they retained in hospital just because they are sick. Their discharge is the result of many factors and events, among them being the nature of the illness, whether adequate benefit resulted from hospitalization, attitudes of the family toward the patient and of the patient toward the family, relationships of the patient with the hospital staff, and of the hospital staff with the family. To be sure, the behaviour of the patient is a major factor in what happens. Undoubtedly there are many patients who are not discharged because nobody wants to take care of them in the home.'

THE DEFINITION OF MENTAL HEALTH

We now turn to more definitive attempts to conceptualize mental health. There are many definitions and their variety is a demonstration of the richness of connotation of the concept as well as its lack of clarity. It will be seen that many of these are influenced by notions from contemporary thinking in biology, medicine, sociology, and even philosophy. They may be usefully grouped under different headings:

1. *Mental Health as a Biological Entity*

This means the measurement of the degree of mental health using basic physiological or psychological standards in much the same way as we measure physical health by objective biochemical or physical means, e.g. haematocrit readings, blood pressure, liver-function tests, etc. There are, as yet, however, no irrefutable physio-chemical data to explain the manifestations of mind and behaviour, and no reliable biological tests of their functioning. Who can say what neuro-physiological processes cause a man to steal and lie or what actually goes on in the brain cells of a philosopher when he suddenly arrives at a new truth? We shall probably be provided with the 'absolutes' that we need in time, but it is clear that at present psychiatry is not as well served by basic biological data as are some of its sister medical disciplines.

In addition, we may perhaps question whether it is permissible to transfer ideas and values which have to do with the biological sciences to the sphere of mental health. Are we justified after all in calling a person sick who is merely unreliable, selfish, swashbuckling, aggressive, or subject to any one of an enormous variety of states which comprise the human condition? It is interesting that those qualities which we categorize as most unhealthy tend to be those which are the most undesirable socially or opprobrious morally. It is perhaps a sign of the greater liberalness of our times that we have now made many of these qualities respectable by linking them, as it were, to the wholly unimpeachable science of medicine. We must however recognize that this is often more an expression of the fact that one of the ways of dealing with human aberrations (which have always exceeded the means of control available) is to make them reprehensible rather than to accept them as evidence of actual disease.

2. *Mental Health as a Subjective State*

Because of the impossibility of objectively assessing the factors which cause mental health, certain definitions use the subjective feeling state of the person as a datum. This is implied, for example, by the use of the term 'well-being' which is embodied in the definition of health given by the World Health Organization:

'Health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity.'

Other criteria used are feelings of contentment, comfort, happiness, or just the fact that a person thinks he is sane and healthy. All these criteria are open to the same criticism: that they involve a subjective judgment of states of feeling and experiencing, e.g. that a person is mentally healthy when he thinks he is. The truth of this depends so much on an individual's capacity for insight and the soundness of his judgment, that assessments made on the basis of these criteria can be most erroneous — in fact, it is only a short step to the grossly deluded psychotic who asserts that he is quite well mentally and that it is only the rest of the world which is mad!

3. *Mental Health as the Capacity for Adjustment to Cultural Norms*

The concept of 'adjustment' is much used as a criterion of mental health, and depends on an assessment of what the person can achieve in relation to what is expected of him in his normal life. Often this means no more than the degree of conformity to the values of the group and the society in which he lives. It forms the basis of many definitions such as that of Menninger:[6] 'It is the adjustment of human beings to the world and to each other with the maximum of effectiveness and happiness. Not just efficiency or just contentment — or the grace of obeying

the rules of the game cheerfully. It is all of these together — it is the ability to maintain an even temper, an alert intelligence, socially considerate behaviour, and a happy disposition. This, I think, is a healthy mind.'

It is clear that much qualification is needed before the capacity for adjustment can be accepted as an absolute criterion of health. For one thing, although personal pliability and adaptability to circumstances will certainly make life easier, it is also a matter of what a person is adjusting to and what the nature of that adjustment is.

Firstly, there is the question of cultural relativity. Human beings have manifold potentialities, and are not committed in detail by their biological constitutions to any particular variety of behaviour although the process of education and acculturation does provide pressure on the individual to think in particular ways and behave according to certain fixed patterns. However, this is not uniformly effective and not everyone conforms to the same degree to the ways and institutions of the society in which he lives, or finds the particular segment of the arc of behaviour that it favours equally congenial. Those whose natural responses fit into the norms of the societies in which they live, are accepted as normal; and those who show deviate patterns of behaviour tend to be called abnormal, and if their behaviour deviates sufficiently from the norm, they are regarded as mentally ill. Benedict[7] makes the point succinctly: 'These are important people for psychiatry. The issue has been too often confused by starting from a fixed list of symptoms instead of from the study of those whose characteristic reactions are deemed valid in the society in which they are born and live'. She gives the example of an individual in Dobu society, who was regarded as ill because he was thoroughly disorientated in his culture. His nature was naturally friendly, and he found activity an end in itself. He was a pleasant fellow who did not seek to overthrow his fellows or to punish them, worked for others, and was tireless in carrying out their commands. He was not filled by a terror of the dark like his fellows, and he did not, as they did, utterly inhibit simple public responses of friendliness toward women closely related, like a wife or sister. In Western European Judeo-Christian cultures we would call this individual normal, since his responses coincide very accurately with what we expect. In Dobu society, however, he was known as a simpleton and regarded as the sort of person who did not fit in.

Another example of the influence of cultural standards in defining mental illness is seen in the rural Bantu who often presents with the symptom of 'a snake in the stomach'. This represents a very concrete invasion of his body to him, but the idea is so prevalent that it is not regarded as delusional in his culture. Similarly, Demkovitz[8] observes: 'Hallucinations are of much less significance than in Europeans. Normal Africans see and speak to their dead parents. The presence of accusing voices or terrifying dwarfs does not necessarily imply a serious mental illness, for they occur in simple depressions and anxiety states and, of course, in hysteria'. It is interesting to note that as Africans become more urbanized and take on the characteristics of Western culture, their mental illnesses also take on more of the flavour of those found among Europeans.

From all this it appears clearly that mental health is not simply a question of adjustment, or learning to manage our lives in conformity with the environment we live in. Moreover, as Wootton *et al.*[9] point out, there is danger in identifying health with the ability to come to terms with cultures or institutions, since these may be unacceptable for very good reasons, e.g. 'totalitarian methods of government, the dingy culture of an urban slum, the contemporary English law of marriage, or the standards of an acquisitive, competitive, hierarchical, envious society'. In other words, if mental health means taking things just as we find them, it may be better to be ill! Another disadvantage of the idea of 'adjustment' is that it places great stress on a scaling down and levelling of values and aspirations so that eccentricity or non-conformity come to be feared and eschewed by all except the ill, the criminal, and the great! "Keeping up with the Jones's" is one of the clearest examples of this sort of social evil which tends to make all men equal despite themselves. However, human nature has always defeated such pressures, for people are full of defections, non-conformity, and unregeneracy. Had it been otherwise the world would have been a very different sort of place; better perhaps, but inestimably duller.

It is unthinkable that it is ever possible to purge people of their essential humanness; and it is undersirable, as Sir Geoffrey Vickers[10] points out, to yoke mental science and modern techniques of persuasion to the task of making everyone well-adjusted to everyone else. Along this road lies mortal danger, not only for the individual but also for society. Saints, artists, creative thinkers and, above all, martyrs, are seldom well-adjusted people, and no civilization can do without them, least of all ours — which changes faster than any has before. 'These are they who incubate tomorrow's orthodoxies through their heretic phase — for all orthodoxies were heresies when they were born. There are the deviants from among whom spiritual evolution will find the material for her next major adaptation. In every age, so far, enough have escaped martyrdom to fertilize the next. It would be ironic if we alone were efficient enough to make ourselves spiritually barren. And not for the sake of the saints and martyrs alone do we reject the cosy heaven of mutual adjustment. Life is an individual affair for each one of us. We cannot fight each other's battles, feel each other's pain, or see each other's visions. The social condition which is integral to us does not make us less than our individual selves. For each of us, as well as for society and posterity, the need to struggle is the chance to grow.'[10]

4. *Mental Health Defined in Terms of a Particular Theory or View of Mental Functioning*

Included under this heading are those definitions which are based on the theoretical postulates of a particular school of psychology, or which are in keeping with what someone regards as the predominantly important part or aim of mental functioning. A definition of the former type, in psychoanalytic terms, is that of Jahoda:[11] 'The mentally healthy person is one who acts according to a consistent inner regulation and is relatively free from conflicts among the three constituent parts of personality (Id, Ego, and Super-Ego) — in other words, an integrated

individual. It is perhaps not quite superfluous to add that this does not imply freedom from conflicts with his environment.'

Another example which stresses a particular conception is that of Lundbye[13] who starts from the basic assumption (which lacks proof and may well be challenged) that maturity is a function of health: 'The mentally healthy person is one who is developing towards personal maturity. Maturity is reached in the same degree as the individual can independently and in a fruitful way overcome his internal conflicts, realize his aims in life, and responsibly live in fellowship with others'.

There are many and diverse definitions of these types, and although it cannot be said in all cases that they are incorrect or not apposite, they are either based on gratuitous assumptions or define mental health in terms of a theory which is in itself unacceptable to all. Then, there are those definitions which resort to what are, in the ultimate, philosophical conceptions. These seek to define mental health not in terms of subjective awareness or sociological usefulness, but in terms of the nature of man and his relation to the temporal world or spiritual values. Definitions involving the use of the word 'reality' are often of this type. One such definition is that of Fromm:[18] 'I would consider that man healthy who had emerged from incestuous attachment to blood and soil; who is capable of experiencing reality, relatively, without parataxic distortions, by reason or objectivity; who is capable of relating himself lovingly to his fellow-man and is able to make productive use of his specifically human powers'.

Definitions such as this clarify nothing because they bring us face to face with greater problems when we try to specify what is meant by 'reality', 'incestuous attachment to blood and soil', or the nature of man. Perhaps the most serious criticism of the usefulness of these definitions is that they offer no practical help in dealing with clinical problems of health and illness. We must also beware of definitions which stress ideal qualities — those that have been psychologically purified or emotionally accepted as normal. These include definitions with strong moral and ethical connotations, or which rely on spiritual values. Let us not confuse purity with normality, nor replace conceptions of social morality with others which mean the same although they are expressed in psychological terms. The position is summed up in an authoritative statement as follows: 'Current concepts of mental health and mental illness are heavily flavoured with morals and ethics, religious fervour, personal investment, invalidated psychological concepts, and are in fact largely composed of pure judgments of value'.[14]

Is there then no valid way of describing mental health in quantitative terms?

We are left with a few possible solutions. Eaton[4] suggests a multidimensional approach — the use of multiple criteria whose validity does not stand or fall by any single set of values. Such an approach is typified by the definition given by the Expert Committee on Mental Health of the World Health Organization,[15] who conceive of mental health as the capacity in an individual to form harmonious relations with others and to participate in, or contribute constructively to, changes in his social and physical environment. It implies also his ability to achieve a harmonious and balanced satisfaction of his own potentially conflicting instinctive drives — harmonious in that it reaches an integrated synthesis rather than a denial of satisfaction to certain instinctive tendencies as a means of avoiding the thwarting of others. It implies in addition an individual whose personality has developed in a way which enables his potentially conflicting instinctive drives to find harmonious expression in the full realization of his potentialities. The shortcoming of definitions of this nature is that the criteria used are decidedly shaky, being thoroughly 'soaked' in value judgments of one sort or another. It must be admitted, however, that on the whole they may give some sort of representative picture since they approach the problems from different angles.

From the above discussion it is clear that mental health *cannot* be adequately defined in theoretical terms. This has lead some authorities to use eminently practical considerations, e.g.:

'A normal individual is one who is free from symptoms, unhampered by mental conflict and who shows satisfactory working capacity, and who is able to love someone apart from himself'.[16]

or more simply still:

'The ability to hold a job, have a family, keep out of trouble with the law, and enjoy the usual opportunities for pleasure'.[17]

There is much to be said for this practical, down-to-earth sort of approach; at least the criteria given are commonplace and easy to assess and apply and they depend on the sound principle that the proper functioning of an organism is the best indication of its state of health. Function means participation in the environment, both internal and external, and is the usual aim of psychiatric treatment — rather than total psychological or mental health, i.e. we endeavour to get the patient to the point where he can participate in his normal life and with his fellows. In fact, most of the criteria that we normally use to assess illness have been shown to depend in essence on the same factors, i.e. occupational circumstances, marital and sexual inadequacy, disturbed interpersonal relations, inability to communicate with others, and so on.[18]

CONCLUSIONS

The above considerations lead us to an important conclusion which contains the answer we have been seeking. The fact of the matter is that, although we are able to describe or enumerate the ordinary effects of being mentally healthy, it is just not possible to define mental health as a thing in itself. The reason is that it is a theoretical concept rather than an actual entity, and not definable in terms of an absolute essence. Moreover, as has been shown, it is an arbitrary shifting concept dependent on numerous different premises, none of which is absolute. Mental health is also largely a question of a system of values which, like all values, can never be proved true or false in the same way as factual data. Consequently, what any person believes to be correct will merely be a point of view or a matter of taste, and we must beware of regarding one set of values as ultimate values just because they replace others which are not quite so satisfactory. It is also quite fruitless to try to elevate

the subject of mental health to the status of a science; it is too sullied with the flavours of invalidated psychological postulates, psychiatric theory, welfare movements, morals, ethics, and even 'cultism'.

Is it then true to say that the idea of mental health has no validity and significance? Nothing in all the above should be construed to mean this; in fact, this article is written with the purpose of demonstrating the richness and practical significance of the idea of mental health, although haziness and lack of definition bedevil it, and as Wootton *et al.*[9] point out, it is still sufficiently real and significant for a world-wide mental health movement to exist, to have a World Federation for Mental Health, and to hold international conferences and congresses. Above all, the concept is important as a rallying point for a great variety of essential activities that have to do with the prevention and treatment of mental illness. Not the least of these is the practical influence which thinking in terms of mental health has had in the field of health and welfare services, helping to bring *humanistic* solutions to problems, rather than the sorts of solutions which are dictated by the social, religious, moral, and legal practices of our technological age. The idea that disturbed or aberrant behaviour is a health problem, while not perhaps always true, has at least the merit of bringing the light that psychology and psychiatry shed into places where it is much needed. For instance, in relation to general hospitals, it may change the general approach in the direction of greater sensitivity towards the personal and human aspects of the patient. In prisons it may lead to a change in atmosphere and attitude among the staff.

In this respect the mental health movement may be looked upon as the preventive arm of psychiatry, which profession has, as a whole, rather tended to neglect the aspect of prophylaxis. Perhaps the most important contribution of the mental health movement has been to influence public attitudes and to reduce the stigma attached to mental illness, thus dissipating fear and prejudice, and encouraging those who need psychiatric help to seek it freely and early. These functions are facilitated because mental health organizations work right in and among ordinary communities, and are readily available to the public. Not the least of the contributions is the effect which the mental health movement has had on the medical profession in helping to shift the interest of psychiatrists from an 'enclosed' field of illness and psychopathology, where the end-products of personal and social disorganization are mainly dealt with, to the community, where the origins and causes of disorder lie. This is the essence of preventive psychiatry.

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OFFICIAL ANNOUNCEMENT

AMENDED NOTICE

THE MEDICAL ASSOCIATION OF SOUTH AFRICA CIRCULAR TO MEMBERS
and
NOTICE OF AN EXTRAORDINARY GENERAL MEETING

Notice is hereby given that an Extraordinary General Meeting of members of the Medical Association of South Africa will be held at the **Festival Hall, Maitland Hotel Maitland Street, Bloemfontein,** and *not* Johannesburg, on the eighth day of March 1961, at 10 a.m., 'with a view to implementing the Medical Services Plan in all provinces of South Africa'.

The meeting is called in terms of the Constitution on a requisition signed by over 100 members of the Association.

Members are advised that travelling expenses and subsistence allowances are not payable for attending a General Meeting of the Association.

At a General Meeting no business shall be transacted unless there be present not less than 50 members in person or by proxy.

For the information of members sub-sections (*d*) and (*e*) of By-law 32 are quoted below:

'(*d*) Every proxy shall be as nearly as material in the following form:

Medical Association of South Africa.

I, A.B., being a Member of the abovementioned Association, hereby appoint C.D. of ..... of whom failing E.F. of ..... also a Member of the said Association as my proxy to appear and vote for me upon all matters to be brought forward at the General Meeting of the Association to be held on the ..... day of ..... 1961, at ....., and at any adjournment thereof.

In witness whereof I have set my hand hereto at..... ..... on this the ..... day of ..... 1961.

Signature of Grantor.

(*Note*—The name of the proxy or proxies must be inserted in the blank left for the purpose in the handwriting of the Grantor himself, and he must affix thereto and cancel a penny and a halfpenny (1½d.) or a one cent (1c.) postage or revenue stamp.)

'(*e*) Proxies shall be delivered to the Secretary prior to the hour fixed for the Meeting at which the same are intended to be acted upon.'

L. M. Marchand
Associate Secretary

28 Plaza Building
Pretoria
18 February 1961

South African Medical Journal : Suid-Afrikaanse Tydskrif vir Geneeskunde

EDITORIAL : VAN DIE REDAKSIE

WHY SOUTH AFRICA IS SHORT OF PSYCHIATRISTS

The answer is simple. There are too few psychiatrists being trained and the speciality is not attractive enough as a career. We must look in several places to see why this is so. The first important factor is the attitude which prevails in medical schools and teaching hospitals where the climate is often such that little is done to encourage the development and popularity of psychiatry. This is, to no small extent, due to the attitude of university administrators and senior physicians in other branches of medicine who, even in this day and age, give psychiatry but grudging approbation.

Psychiatry thus comes to be looked upon by medical students as one of the relatively minor subjects of secondary status in the curriculum, which is dwarfed in importance by such colossi as medicine, surgery, and gynaecology and obstetrics. However, psychiatry can no longer be denied importance since it is so patently and inextricably enmeshed in all the branches of medicine. It cuts across the boundaries of all specialities and in one form or another is part of the daily work of any doctor. Approximately 50% (some authorities say more) of all cases presenting in non-psychiatric practice show psychogenic disorder of some sort. Furthermore, the number of hospital beds for the mentally ill in South Africa is almost 50% of the total number of general hospital beds available.

The fact of the matter is that psychiatry is still the stepchild of medicine and, although it has expanded enormously in recent years within itself (there being a great increase of knowledge and therapeutic efficiency), the recognition accorded to psychiatry by other branches of the profession is still grudging and slow to come. This can be judged from the fact that in the five medical schools in South Africa there is but one full-time professor in psychological medicine. For the most part, the subject is taught part-time by psychiatrists who are in private practice, or by senior doctors from the mental hospital in the area. These men do their best, but they have heavy responsibilities coping with busy practices or administering large mental hospitals at the same time.

Psychiatry is a vast and difficult subject and calls for a full-time professor wherever it is taught. This professor must work in close association with his colleagues in the other branches of medicine, i.e. in gynaecology, medicine, obstetric units, children's wards, etc. It is the lack of such full-time posts that has hampered and curtailed the development of psychiatric services and the training of doctors in undergraduate and postgraduate psychiatry more than any other single factor, and it is considered a matter of urgency that the situation be rectified by medical schools.

The syllabus of undergraduate psychiatry should also be reconsidered. Why is so little time apportioned to psychiatry in certain schools in view of the fact that psychiatric practice constitutes such a large portion of medical practice in general? Reasons of all sorts continue to be advanced to explain this, e.g. the medical course is already overloaded, and many other important subjects should also be apportioned more time, etc. However, the fact remains that more time is needed and the situation should be investigated to see how this could be achieved.

Psychiatry as a subject must also be made more attractive to the student if we are to kindle an abiding interest in psychiatry in him. This means providing the student with an adequate knowledge of those problems which he will meet with in everyday practice, that is, not only pathological states, but also a knowledge of normal personality structure and development, and an understanding of human behaviour.

To be successful, the training-experience of the student must provide him with insight into his own motives and attitudes, particularly in so far as they affect his relationships with other people. Psychiatry must be presented to him simply in the language of everday usage, avoiding jargon and too much theory. More emphasis should be put on the useful art of psychotherapy which he will use all day long, and less on abstruse theories, 'deep' psychopathology, and a partisan approach to the many problems of modern psychology and psychiatry. Undergraduate training in psychiatry must of necessity aim at providing adequate instruction for the average student who will not initially be interested in specialization and who later on will deal with all types of patients.

However, it is not only the universities who are blameworthy in this regard, but also many senior members of the profession who, unfortunately, still regard psychiatric illness with suspicion. Psychiatry is even now not quite 'respectable' and they tend to perpetuate this attitude not only in the minds of their junior colleagues and students, but also among their patients — 'Why bother with the psychiatrist?', they say, 'you're as normal as I am!'

It must of course be realized that they are not entirely to blame because they 'grew up' medically and were educated in an era in which a rather dry and dehumanized classificatory psychiatry existed. They were largely taught about major mental illnesses, most of which are uncommon in ordinary practice, e.g. general paralysis of the insane, schizophrenia, presenile psychoses, etc., but received little instruction about those conditions which constitute the bulk of present-day psychological medicine, i.e. the emotional disturbances of everyday people, personality problems, problem-drinking, absenteeism in industry, the management of retarded children, marriage-guidance counselling, the psychological problems of industrial workers, the emotional disturbances of lonely old people, the handling of disturbed behaviour in children, the guidance of adolescents, and so on. The answer to all this, quite simply, is re-education, for

instance by means of refresher courses. These courses should be encouraged by all possible means, since the field of mental health, more than most other specialities, has undergone enormous expansion in the last few years.

There are several other reasons why young doctors are not attracted to psychiatry, and it is felt that there are several measures that could be taken by the State mental hospital service to improve matters. The mental hospitals have always trained doctors 'in service' for their own institutional needs, but have been satisfied to let it rest at that. They have not really been concerned to train men for work outside of their service, or to serve the public in private practice.

Much could be done if a forward-looking policy were instituted to encourage this. Scholarships and opportunities to study for higher degrees, and preparation for a wider field of activity, would redound to their own direct advantage as well as providing more psychiatrists to serve the public. This is becoming all the more important because the expanding needs of a community psychiatric service — the psychiatry of the future — will demand large numbers of highly trained psychiatrists. It is no longer enough to provide only for certifiable inpatients; we also have to look to the ever-increasing number of certifiable cases outside mental hospitals.

Furthermore, the mental hospital service, which is by far the largest single employer of psychiatrists in South Africa, has certain disadvantages for the young doctor wishing to make it a career. This is shown by the fact that without the considerable number of temporary staff appointments that have had to be allowed because of the shortage of suitable permanent staff, the service would hardly be able to staff its various hospitals. Young doctors are discouraged by the fact that the service has tended, all too often, to become detached from the main stream of medicine. For example, mental hospital psychiatrists do not always have the stimulation of professional contacts that comes to their colleagues who work in psychiatric departments of general hospitals. Much would be gained in attractiveness if it were possible for these men to move freely into various other hospitals and posts. At present the division of responsibility for health services between the State and the Provinces makes this impossible. There is, for instance, a difference in salary scales. There is therefore much to be said for any scheme which makes it possible for psychiatrists to move freely from say, a mental hospital, to a psychiatric ward in a general hospital, a community psychiatric service, a child guidance clinic, or a specialized provincial hospital such as Tara. Important changes in the administration of the mental hospitals and the treatment of mental illness (including the establishment of outpatient clinics at the mental hospitals) are however envisaged in terms of the Mental Disorders Amendment Bill which, at the time of writing, is being debated in Parliament.

It would also be an incentive if certain posts in mental hospitals were put on a part-time basis, thereby allowing psychiatrists in private practice a much greater opportunity (as far as hospital appointments are concerned) and increasing the scope and interest of their work.

Other measures that would assist in drawing medical practitioners to psychiatry are a series of scholarships to pay for postgraduate studies, and the encouragement of universities to provide training for the Diploma in Psychological Medicine (the University of the Witwatersrand is the only university that provides this course). More advantage should be taken of the newly-instituted course for the D.P.M. by the College of Physicians, Surgeons and Gynaecologists of South Africa. Universities and teaching hospitals could assist by providing courses of instruction to prepare students for this examination. The establishment in South Africa of facilities for the training of psychoanalysts is also necessary, since there is a dearth of such experts and several promising young men have left the country in order to obtain this training which is not available here. A certain number of suitable persons might also be drawn to the speciality if a course to train child psychiatrists were instituted somewhere in South Africa.

The urgent need to train non-White psychiatrists should also be borne in mind. The situation is bad enough as regards the Europeans, but it is infinitely worse when the position in the whole of the Union of South Africa is considered. There is not one such trained person to cater for the needs of the non-White population. The recruitment and training of non-White psychiatrists must therefore be regarded as a matter of extreme urgency.

OPLEIDING IN DIE PSIGIATRIE

Dit het al gebruiklik geword in Suid-Afrika om die eerste week in Maart van elke jaar te beskou as geestesgesondheidsweek. Gedurende dié week word daar dan besondere pogings aangewend om die mediese en maatskaplike aspekte van die probleme van geestesongesteldheid onder die aandag van geneeshere en ander lede van die publiek te bring.

Dit is goed dat hierdie gebruik ontstaan het, want dit bied die geleentheid om by herhaling en vernuwing sommige van die moeilikste probleme waarvoor ons as enkelinge sowel as 'n gemeenskap te staan gekom het, onder die soeklig van kritiese beskouing te plaas. In hierdie uitgawe van die *Tydskrif* plaas ons dan ook 'n aantal spesiale artikels waarin verskillende fasette van die probleme van geestesongesteldheid en geestesgesondheid gestel word.

Dit is nie ons doel om hier te probeer om die hele probleemgebied in hierdie verband te dek nie. Dit sou trouens ook nie moontlik wees nie. Wat ons egter wel wil doen is om een kardinale probleem te noem en na die implikasies van die beduidendheid daarvan te verwys.

Die probleem waarna ons wil verwys is naamlik die kwessie van die psigiatriese opleiding — veral die voorgraadse opleiding — van mediese studente in die algemeen. Dat daar op hierdie gebied 'n ernstige skroef los is — en dit geld vir *al* ons mediese skole — ly geen twyfel nie. Die feit van die saak is dat ons in ons opleiding aan ons mediese skole *nie* daarin slaag om die belangstelling by mediese studente vir die psigiatrie te wek nie. Meer belangrik en meer ernstig is die feit dat ons gedurende die loop van die mediese kursus studente, wat met 'n belangstelling in die psigiatrie begin, so afskrik dat hulle vir die res van hul lewe wye draaie om die vak loop.

Die stelling wat nou net gemaak is, het ernstige implikasies en dit werp natuurlik ook ernstige refleksies op die opleiding van studente op hierdie gebied. Die stelling is egter onweerlegbaar omdat dit berus op die persoonlike getuienis en ervaring van senior studente en dokters wat onlangs gekwalifiseer het. Die feit van die saak is dat hierdie ongelukkige saak 'n feit is!

Ons kan die toestand van sake slegs die hoof bied as ons ons hele benadering tot die psigiatrie verander. In die eerste plaas moet die psigiatrie ontwortel word uit sy *asielatmosfeer* en geïntegreer word met die algemene medisyne en die moderne praktyk.

Tweedens moet die nodige en noodsaaklike *atmosfeer* vir die vak geskep word. Daar moet 'n leerstoel in die psigiatrie aan elkeen van ons universiteite geskep word met 'n professor aan die hoof, wat dan verantwoordelik moet wees vir die skepping van so 'n akademiese atmosfeer dat dit die verbeelding van studente sal prikkel ten opsigte van die probleme van die psigiatriese praktyk.

Derdens moet die hele instelling van voorgraadse psigiatriese opleiding radikaal verander word. Dit is tyd dat eens en vir altyd halt geroep word aan die erbarmlike pseudo-Freudiaanse en pseudoanalitiese geploeter. Ons moet ophou om hierdie gekkemans-bedrog (almal outentieke voorbeelde) aan studente oor te dra: dat die beeld van saailande beteken dat 'n pasiënt verlang na sy moeder se geslaghare; dat teensinnigheid om op 'n roltrap te ry 'n vrees vir geslagsgemeenskap verraai; dat 'n hol klip 'n vroulike geslagsimbool is, ens., ens. *ad infinitum* en *ad nauseam*.

Ons moet studente bekendstel met die soort psigiatriese probleme wat hulle sal teenkom en wat hulle sal moet hanteer — op 'n praktiese vlak en op die basis van gesonde verstand. Ons moet al daardie elemente drasties weer uit ons psigiatriese opleiding, wat die psigiatrie en die psigiater tot spot van alle mense met insig en oordeel gemaak het. Dan kan ons die vak psigiatrie as wetenskap en as praktiese kuns opbou en dan sal ons daarin slaag om die verbeelding van studente aan te gryp en aan te vuur.

AN INTELLIGENCE OF THE HEART*

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I propose to review some aspects of modern psychiatric thought and practice, which have reference to those problems of the everyday practice of medicine which soon will confront you as medical practitioners. An understanding, not only of the science, but also of the art of medicine is required if you are properly to fulfil your responsibilities to your patients.

It is perhaps the possibility that psychiatry has a worthwhile contribution to make to what has hitherto been only rather vaguely understood by the term 'The art of medicine', that has determined the inclusion of a psychiatrist in this revision course.

The phrase *An intelligence of the heart*, which came my way but a few weeks ago, seems to me admirably to delineate that 'without which not' of good medical practice.

Just as general medicine has only recently come to derive benefit from the insights of psychological medicine, so has psychiatry (regrettably also only recently) come to maturation as a result of the application of that vital essence, *the scientific method*, long familiar to the physician.

The cross fertilization of the two disciplines, medicine and psychiatry, has led to a recognition of the importance of what has been called *the second question*. Our training has taught us how to try to answer the question: What sort of *illness* has the patient? We must, however, never omit to try, too, to enquire: What sort of *patient* has the illness?

We have referred to the scientific method. In basic form it consists of 5 essential and consequential steps. Let us briefly consider them:

1. Collecting information.
2. Checking the information gathered.
3. Erecting an hypothesis to comprehend the 'facts' so checked.
4. Testing the hypothesis on the basis of its ability accurately to predict an outcome (e.g. when submitted to controlled experiment).
5. Evaluating the substantiated hypothesis and determining a scientific 'law'.

In medicine these steps are respectively:—

1. Obtaining a history.
2. Carrying out a physical examination.
3. Arriving at a provisional diagnosis.
4. Performing laboratory, radiological, and other tests and/or embarking on a therapeutic trial of specific medication.
5. Arriving at a final diagnosis (which in some cases may be obtainable only after operative exploration or at post-mortem examination).

In psychiatric practice, physical and neurological examination (including routine testing of the urine) is often negative. How then are we to check the information given by the patient? The answer is to obtain histories, with the patient's permission, from those who know him and have an interest in his welfare — the husband or wife, parents or children, employer or teacher, and so on.

Where this information is not readily available, a period of observation in a nursing home or hospital will enable the nursing sister in charge of the ward, the occupational therapist, relaxational therapist, and social worker to obtain the information necessary to arrive at a diagnosis.

The information obtained from sources other than the patient is extremely worth while also in cases suffering from organic disease and could usefully become routine in all branches of medicine. The old-fashioned family practitioner who had all this additional information at his fingertips by reason of his close and warm relationship with the whole family, knew how important this often-neglected information can be.

Heredity and Environment

Before discussing the psychiatric disorders, a brief reference must be made to the question of heredity and environment in their aetiology. The position has well been summarized in the statement 'Heredity deals the cards, environment plays the hand'. As you know, many a good hand dealt has been poorly played and, contrariwise, many a mediocre hand so well managed as to win the game. It is well to remember that it isn't so much the size of the dog in the fight, as the size of the fight in the dog that counts. The question is not of 'heredity *or* environment', but rather how much of one and how much of the other.

* Valedictory address to Final year Students, Medical School, University of the Witwatersrand, 28 September 1960.

The old concept of an illness being caused by a pathology has been replaced by the modern concept of the sick person with 'built-in' tolerances and sensitivities reacting to many interacting stresses — genetically determined deficiencies, bacterial and other invasions, social and interpersonal difficulties, toxic and climatic strains, and so on.

CATEGORIES OF MENTAL ILLNESS

In presenting a more scientific framework of reference of psychiatric illness, we may start by dividing mental illness into 2 chief categories:

(*a*) Major mental illnesses — the *psychoses*
(*b*) Minor mental illnesses — the *psychoneuroses*.

The suffix '-osis' indicates 'something wrong with'.

In the original concept, then, the term psychosis meant 'something wrong with the psyche', whereas the term psychoneurosis meant 'something wrong with the neurones (i.e. the central nervous system) leading to disorder of the psyche'.

This outmoded application of these terms can now be abandoned in favour of that set forth above which, while maintaining traditional terms, gives them dynamic and up-to-date connotations.

A. The Psychoses or Major Mental Illnesses

These fall into two classes:

1. *The Organic Psychoses*

Whatever the nature of the brain pathology — whether due to genetic defect, intra-uterine disease or postnatal trauma, infection (bacterial, viral or parasitic), neoplasm, toxaemia (exogenous or endogenous), cardiovascular dysfunction, or haemopoietic disorder — all of these present either in (*a*) acute disturbance (the deliria), or (*b*) chronic disturbance (the dementias), or (*c*) a combination of these.

The disturbance of mind which is brought about in its 3 manifestations — *knowing, feeling* and *doing* — is dramatic and eruptive in the deliria and gradual and dilapidative in the dementias. In either the practitioner must apply himself, after consideration of the history from patient and others, and after physical and neurological examination and ancillary investigations, to the task of determining what pathology exists in the central nervous system with a view to giving appropriate and specific treatment to aetiological factors in addition to the general and non-specific care, supervision and control of the psychic manifestations. The latter are best dealt with by suitably trained and efficient nursing staff. The commonest mistake in the treatment of these conditions is an attempt to substitute sedation for nursing, with the inevitable result that a drug-confusional state is added to the underlying delirium or dementia.

2. *The Functional Psychoses*

These include the conditions in which the psychic disturbance is not due to an ascertainable structural disorder of brain. The 2 chief conditions in this group are:

(*a*) The manic / depressive psychoses. The manic patient knows everything, feels fine and is busy doing everything — the 3 functions of mind being all together elevated 'above the line' (of normality). The melancholic patient knows nothing, feels low-spirited and does nothing — the functions of mind are together depressed 'below the line' (of normality).

The outlook of the melancholic is well set forth in the rhyme entitled 'The Pessimist'.

'Nothing to do but work,
Nothing to eat but food,
Nothing to wear but clothes,
To keep one from going nude.

Nothing to breathe but air,
Quick as a flash 'tis gone;
Nowhere to fall but off,
Nowhere to stand but on.

Nothing to comb but hair,
Nowhere to sleep but in bed,
Nothing to weep but tears,
Nothing to bury but dead.'

The depressions very often come out of the blue but on occasion are precipitated by external events.

THE SORROWS OF WERTHER

'Werther had a love for Charlotte
Such as words could never utter;
Would you know how first he met her?
She was cutting bread and butter.

Charlotte was a married lady,
And a moral man was Werther,
And for all the wealth of Indies,
Would do nothing for to hurt her.

So he sigh'd and pined and ogled,
And his passion boil'd and bubbled,
Till he blew his silly brains out,
And no more was by it troubled.

Charlotte, having seen his body
Borne before her on a shutter,
Like a well-conducted person,
Went on cutting bread and butter.'

It must always be remembered that what appears catastrophic to the onlooker unaware of the total context of the situation, may have a personal significance for those involved which is quite different. For example, the case of Margaret and Augustus:

'Eating more than he was able
Augustus died at breakfast table.
"If you please", said little Meg,
"May I have his other egg"?'

(*b*) The schizophrenias (C I H N / h O e A). Here there is a splintering and disintegration of the personality and the bonds between knowing, feeling and doing are, as it were, broken so that action and feeling are no longer appropriate to associated thought, e.g. the woman convinced she is the Queen of Spain, yet quite indifferent about being on her knees scrubbing the ward floor.

B. The Psychoneuroses or Minor Mental Illnesses

Lack of a more or less consistent admixture of affection ('love', 'warmth', 'security') and discipline (in the sense of tuition and example regarding the need to consider the needs of others as well as one's own) are basically important in the genesis of all the minor mental illnesses.

These fall into 5 classes: (*i*) The anxiety hysterias, (*ii*) the obsessional disorders, (*iii*) the psychosomatic disorders, (*iv*) the reactive depressions, and (*v*) the character neuroses.

(*i*) The anxiety-hysterias are considered together because anxiety states rarely fail to show some hysterical manifestations, and hysterics rarely completely 'convert' their anxiety. This disorder tends to occur more predominantly in the lower I.Q. range.

(*ii*) The obsessional disorders constitute a variant of the anxiety state in which repetitive rumination and occasional ritualistic compulsion manifest themselves. This disorder tends to occur more frequently in the higher I.Q. range.

(*iii*) The psychosomatic disorders. This other variant of the anxiety state, in which emphasis is placed upon the somatic manifestations of anxiety, has proved to be acceptable as a diagnosis to both the medical practitioner and his patient.

(*iv*) The reactive depressions, as the name implies, refer to depressions predominantly the result of circumstance — loss of a loved one, or failure, as the usual causes of this grief reaction. In contrast to the endogenous melancholic depression, the patient with a reactive depression does not necessarily feel at his worst in the early morning, nor does he improve as the day goes on. His depression varies as the circum-

stances vary. He has difficulty in getting off to sleep; once asleep he sleeps through, again in contrast to the melancholic who has no initial difficulty but wakes after an hour or two, then remains awake.

(*v*) The character neuroses. The antisocial manifestations of the patient's personality disturbance are prominent in this category. The patient is said to 'act out' his conflicts in contrast with the other 4 sub-groups, in which his problems are internalized.

One of the interesting manifestations of either character neurosis or psychoneurosis is the so-called accident proneness. This is of importance in industry and on the road where it leads to the disease of road accidents. An amusing and transient manifestation of this interesting condition is reported in a recent issue of the *Lancet*.

'My friend Giles was accident-prone for a fortnight; and that, he swears, was long enough. Soon after we arrived on holiday he chanced to see a tall blonde goddess watching his tennis. This inspired him to such Hoad-like activity that he won his match. Alive to the fullness of the moment, he rushed across the court and leapt the net. Unfortunately, he did not quite make it. He met the young lady a few evenings later at the weekly dance. She was a nurse, he discovered, when she gave him first-aid for the cup of tea he cascaded into his left shoe. Probably on the principle of humouring the patient, she agreed to go sailing with him the next afternoon.

'At the appointed time Giles escorted her aboard the waiting dinghy. Despite some spirited poling with an inverted oar the boat refused to budge from its bed of sand. Nothing daunted, Giles slid over the stern and gave a few manly pushes under the expectant gaze of his lady. Still the vessel remained fast until, at last, with a superhuman heave he set it in motion. Unhappily, at the same time, he stood on a piece of seaweed. As the dinghy surged forward Giles dived headlong into the deep blue sea. The rescue operation was interesting: Giles, dazed and dripping, was hauled to the shore while a boat was launched in pursuit of his companion, who, being no sailor, was gliding helplessly out over the bay.

'How he managed to persuade her to walk with him the following evening is beyond my comprehension: but, as the sun set, they were strolling along a country lane, Giles relating how he had won a medal for the high jump at school. Should she care, he would demonstrate the style that had won him this honour. The look of awful anticipation on her face did not escape him, but, he said, not to worry, he would do no more than demonstrate on that three-foot wall. The plaintive wail and dull thud which followed his disappearance, if not new, was still alarming. Rushing to the wall and looking over she beheld Giles on his back, groaning, in a sunken field, six feet below road level.

'Giles has had fewer accidents lately. His wife, a tall blonde girl, takes good care of him: she says he evokes her nursing instincts more than any patient ever did.'

C. Intermediate Conditions

Intermediate between the psychoses and the psychoneuroses, as defined above, are the instances of:

(*a*) the minor psychoses and
(*b*) the major psychoneuroses.

(*a*) *The Minor Psychoses*

Early stages, or minor versions of the psychoses, both organic and functional, may be confused with the psychoneuroses. The mild nocturnal confusional state occurring in the chronic alcoholic, the 'hysterical manifestations' (catastrophic reactions) of the dementing patient (whether due to senility, arteriosclerosis or the slow development of a cerebral tumour), the so-called post-traumatic personality syndrome (mild post-traumatic dementia) are examples in the organic category of psychosis. Minor melancholia (pseudo-neurotic melancholia) and very early schizophrenic disintegration (pseudo-neurotic schizophrenia) are examples in the functional category of psychosis.

(*b*) *The Major Psychoneuroses*

A special word must be said about melancholia minor. This commonly occurring condition manifests the classical hallmarks of melancholia though in mild form. Often masquerading as organic disease of bodily systems, its true nature is often not recognized until the tragic suicide of the patient.

Similarly, the chronic and severely disabling obsessional disorder (obsessional 'psychosis'), the profound psychopathic disturbance, and the severe hysterical regressions are examples from the category of the psychoneuroses of severely incapacitating illness.

TREATMENT IN PSYCHIATRY

It has been said that treatment begins as soon as the effort has been made to establish contact with the patient in an attempt to make a diagnosis, i.e. to understand the patient's problems.

The chief categories of treatment in psychiatry are: (*i*) psychotherapy, (*ii*) environmental manipulation, (*iii*) chemotherapy, and (*iv*) the so-called 'physical' types of treatment — the various electrotherapies, and the insulin therapies (low and high dosage).

(*i*) *Psychotherapy*

This is, in essence, conversation, designed to sort out, and work out, the patient's problems.

The range extends from brief, directive, face-to-face, across-the-desk, common-sense therapy, to prolonged, non-directive, on-the-couch, psycho-analytical therapy.

(*ii*) *Environmental Manipulation*

Under this heading come all the devices for separating the anxious and disturbed patient from stress and responsibility, ranging from a few days off work, or a few weeks of holiday, to admission to a nursing home to *get away from it all* for a while and permit the administration by the nursing staff of large doses of tender, loving care.

Change of employment (square peg in round hole), advice re hobbies and recreation, change of residence (flat to house or *vice versa*), change of teacher, school, boarding school, extra lessons, etc., are the various devices used by every practitioner (and psychiatrist) in addition to the other forms of therapy available.

It is important to formulate a programme of treatment incorporating in various ways the different therapies available. It is also important to discuss the programme both with the patient and his relatives, attempting to include the latter as far as possible in the therapeutic team who, working together, will assist the patient to deal with his difficulties.

(*iii*) *Chemotherapy*

Chemotherapy includes the administration of symptomatic tranquillizers, sedatives, hypnotics, and stimulants, as well as the whole new range of chlorpromazine derivatives (which have largely displaced high-dosage insulin therapy in the treatment of schizophrenia) and the 'specific' anti-depressive drugs, including monoamine-oxidase inhibitors.

(*iv*) *Physical Treatment*

Electro-convulsive therapy is almost universally administered under intravenous pentothal anaesthesia together with 'scoline', or a similar muscular relaxant. The pentothal removes unpleasant associations (mouth gag, forehead electrodes), and the relaxant obviates the risk of musculo-skeletal injury.

This technique has enabled electro-convulsive therapy to be given on an outpatient basis in suitable cases, thereby avoiding prolonged hospital inpatient treatment.

The severely agitated or depressed patient still requires the initial period of hospitalization to obviate the risk of suicide. The possible benefits of the newer anti-depressive drugs must not lull the practitioner into a false sense of security or into an attempt to avoid this most effective treatment in severely distressed cases where death appears a welcome relief from the agony of mind suffered by these unfortunate people.

Low-dosage insulin, administered daily on waking in

increasing doses to the point of sweating and tremor, can only be given in a hospital or nursing home where facilities for the immediate interruption of a hypoglycaemic coma are available. This treatment stimulates the appetite in a remarkable manner and is useful for the anorexic or underweight patient, as well as being of great use in the treatment of the addictions, particularly to habit-forming drugs.

High-dosage insulin (insulin coma treatment) is less used today than it was. It is still useful for those cases of schizophrenia or melancholia where response to the other therapies has proved unsatisfactory.

IATROGENIC HAZARDS

Before the unfortunate psychoneurotic patient can receive the treatment that will help him, he has several hurdles to surmount. Concern with the stigma associated with mental illness and its treatment is unfortunately compounded by the medical man's attitude to these disorders. Iatrogenic difficulties are added to those arising from illness and social prejudice.

(*a*) When the physician, having failed to elicit evidence of organic disease, uses such phrases for the melancholic as 'There is nothing wrong with you' or 'pull yourself together', or 'It is all up to you', the evidence of the absence of understanding, patience, or compassion on the part of the medical attendant may result in the patient abandoning hope of help from doctors, thus fortifying his resolution to 'end it all', or it may lead to his seeking help elsewhere, turning to the hosts of *non-medical* practitioners, ranging from naturopaths to spiritual healers who will be only too ready to receive these medical rejects sympathetically.

(*b*) If the patient is warned that 'unless he stops his nonsense and gets on with the business of living, he will land up in the mental hospital', this offensive, almost negligent, advice will certainly tend to have the effect of keeping the patient away from psychiatrists and from all the advances in modern therapy that they have to offer for the relief of this unfortunate condition.

An example of this sort of thing occurred in the case of an unfortunate woman aged 63, who was first seen in March 1956, with classical symptoms of melancholia. One of her complaints was epigastric pain, present on waking at four o'clock in the morning and improving towards afternoon. She had been admitted by her physician to a nursing home during which time the proposition had been put to the physician that the patient see a psychiatrist. His response was, 'Keep away from them or you will land up in Tara'. The general practitioner felt he ought first to have removed some gallstones which had been present for many years and which he had determined were likely to be responsible for her abdominal pain before allowing her to have ECT. Following cholecystectomy, her agitation and distress became very much more marked and, while convalescing at home, she threw herself into her swimming pool and, for the first time, I was allowed to take over and go ahead.

(*c*) If the condition is mistaken for an anxiety state either because agitation or hypochondriasis masks the depression, or because (as in melancholia minor) the depression does not appear profound enough to be 'psychotic', and the patient is given long-acting barbiturates (which tend to depress him further) or bromides (which in effective dosage tend to confuse the patient), then he is once again apt to come to the conclusion that the cure is worse than the disease.

(*d*) Finally, if the medical practitioner believes that the newer anti-depressive compounds are invariably effective when given for a period of up to 6 weeks, then not only must the unfortunate patient suffer a further prolonged period of anguish, but at the end of this period there is an appreciable chance that he will be no better at all. A recent study, for example, indicates that a certain chemotherapeutic agent (not a monoamine-oxidase inhibitor) has, at the end of the so-called effective period of time, a substantial failure rate (in the neighbourhood of 30% - 40%). Furthermore, all these drugs are liable to cause various side-effects, some uncomfortable, some dangerous, during the period that their beneficial effects are being awaited. The unfortunate patient cannot always wait as long as this and tolerates poorly any symptoms over and above those he already has.

In this connection Sir Robert Hutchison had this to say: 'I think there should be a new petition in the litany to be read in hospital chapels or wherever doctors and nurses do, or ought to, congregate. It might be as follows: "From inability to let well alone; from too much zeal for the new and contempt for what is old; from putting knowledge before wisdom, science before art, and cleverness before common sense; from treating patients as cases, and from making the cure of the disease more grievous than the endurance of the same, Good Lord, deliver us".'

To conclude, I have demonstrated that psychological medicine, scientifically disciplined, has a contribution to make to the practice of the art of medicine.

May I mention the final ingredient in the mixture which makes for harmony between patient and doctor, and doctor and doctor? I refer to courtesy based on a consideration of the needs of the other person — a true appreciation of the necessity of the golden rule — 'To do unto others as you would have them do unto you'.

SIX CASES OF CEREBELLAR DEGENERATION ASSOCIATED WITH CHRONIC ALCOHOLISM

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A well-recognized symptom of acute alcoholism is a temporary interference with coordination. This usually persists for some hours or days after cessation of drinking, but may occasionally persist for a week or more, and has been attributed to the 'toxic' effect of alcohol on the cerebellum. Until fairly recently it was not generally appreciated that irreversible cerebellar degeneration might result from chronic alcoholism. (Indeed it is becoming more and more apparent that alcohol can be associated with damage to any part of the nervous system.) During the last 2 years there have been several reports of cases of chronic cerebellar degeneration associated with chronic alcoholism. The most impressive of these is a report by Victor, Adams and Mancall[1] on the clinical details of 50 cases and autopsy details of 11 cases. These authors were struck by the uniformity of the clinical picture. Almost invariably the gait and lower limbs were grossly affected; the upper limbs were often not affected and dysarthria and nystagmus were uncommon.

'The essential pathological change in 11 autopsied cases was a degeneration of all the neurocellular elements (but especially of the Purkinje cells) of the cerebellar cortex. This degeneration was strikingly selective in that it was restricted to the anterior and superior aspects of the vermis and the hemispheres. The olivary nuclei were almost always involved; the fastigial, globose, emboliform

and vestibular nuclei were less consistently affected. The dentate nuclei, cerebellar white matter and peduncles, the spinocerebellar tracts and other brain-stem nuclei were essentially unaltered'.[3] The portion of the cerebellum which lies anterior to the primary fissure is generally regarded as the 'leg area' in experimental animals and this explains the predominant involvement of lower limbs seen clinically.

From August 1959 to May 1960, 6 chronic alcoholic patients with cerebellar degeneration were admitted to Groote Schuur Hospital. The clinical details are presented.

CASE REPORTS

1. W.E. (European male), aged 49 years

This patient was admitted to the ward in August 1959. He stated that he had been unsteady on his feet since 1955 or 1956. The onset of the unsteadiness was slow but had been steadily progressive, so that he had been afraid to walk in the dark during the last few months. He had to use his arms to pull himself up when climbing stairs.

On examination his general condition was good. He was normotensive. The liver was 3 fingerbreadths below the costal margin, and firm but not tender on palpation. The pupils were small and slightly irregular, and reacted sluggishly to light.

The upper limbs were normal in power, tone, reflexes, sensation and coordination.

In the lower limbs there was no motor weakness but the tone was diminished and the ankle jerks were only just elicited with reinforcement. There was some patchy diminution of light touch and diminution of pain sensation over the dorsum of the feet. Calf-muscle tenderness was not increased. There was gross heel-knee ataxia, marked ataxia on attempting to walk along a straight line and marked Rombergism. The cerebrospinal-fluid chemistry and serology were normal. Blood serology was normal. The patient was given a full diet, 'plebex' intramuscularly, and later vitamin-B compound by mouth. He was discharged 4 weeks after admission and on discharge could walk along a straight line, his heel-knee ataxia was less marked, and Romberg's test was negative.

2. C.D. (Coloured male), aged 35 years

This man was admitted in August 1959, complaining that for a year he had had difficulty in walking. He could not analyse this difficulty precisely but said that his feet felt 'heavy' and he was not quite sure where they were on the ground. This difficulty with walking had progressed to such an extent that for 3 weeks before admission he had been bedridden. For 6 months his speech had been indistinct. For 2 months he had had a dull pain in the lower limbs.

On examination his general condition was good. Blood pressure was 150/100 mm.Hg. The liver was 2 fingerbreadths below the costal margin and firm to palpation. Mild dysarthria was present. The upper limbs were normal apart from mild incoordination in the finger-nose test. In the lower limbs the knee and ankle jerks were absent and the calf muscles were tender. There was gross heel-knee ataxia and his gait was ataxic. (Incidental findings were a positive blood serology and a slightly widened aorta. He was given 36 million units of penicillin while in the ward.)

He was discharged after 3 weeks with his condition unchanged. He was re-admitted in January 1960, and stated that he was walking better, his speech was more distinct and his calves were no longer tender. He had cut down his drinking to some extent. On examination he had minimal dysarthria. The right upper limb showed a coarse tremor at rest but coordination was probably normal. There was gross heel-knee ataxia and heel-toe incoordination was present when walking.

3. N.S. (European female), aged 39 years

This patient was incapable of giving an adequate account of herself and no relatives or friends could be interviewed. In July 1959 she was admitted to a hospital with a diagnosis of Korsakoff's syndrome, peripheral neuritis and Wernicke's encephalopathy. In August she was transferred to a convalescent home and was reported at that time to be normally ambulant, helpful and cooperative, but vague about her past. While at the convalescent home she developed increasing tremor and became unable to walk or to feed herself. She was admitted to Groote Schuur Hospital in December 1959.

On examination she was in good general condition. She cooperated well in examination and her attention was sustained. There was no overt evidence of intellectual deterioration and tests of arithmetical ability were well done. However, the simplest questions demonstrated gross memory impairment, especially for recent events and all details of her illness. There was a marked nodding tremor of the head and at rest an occasional and variable tremor was present affecting the thumb or a finger; it consisted of a slight abduction-adduction movement. Voluntary movements accentuated this tremor and it spread so that a pronation-supination movement of the forearm was noted in addition to a tremor of the leg when carrying out the heel-knee test.

There was moderate dysarthria with a 'scanning' element to the speech. Nystagmus was not present, there was no cranial-nerve defect, and power, reflexes and sensation were normal. Tests of cerebellar function, however, demonstrated marked ataxia and tremor in the finger-nose test but fairly good performance of rapidly alternating movements. In the lower limbs there was no heel-knee ataxia and toe-object touching was normal. Stance and gait were grossly abnormal. The patient stood on a wide base with knees hyper-extended and involuntarily sought support.

The cerebrospinal fluid and the serum proteins were normal. Electro-encephalography showed generally low-voltage wires with irregular fast frequencies and some random slow α-activity.

She was discharged in April 1960 and, despite intensive vitamin therapy and physiotherapy, had made no essential progress.

4. E.S. (African female), aged 58 years

This patient had noticed increasing unsteadiness of gait for 10 months. For 2 months before admission she was unable to walk without support.

On examination her general condition was good but she was moderately hypertensive (blood pressure 170/105 mm.Hg).

The only neurological abnormalities were a grossly ataxic gait, gross heel-knee ataxia and intention tremor of the right leg on toe-object testing, in addition to mild peripheral neuritis (sluggish ankle jerks and increased calf-muscle tenderness). Liver-function tests and serum proteins were normal. Cerebrospinal-fluid chemistry and serology were normal. The electro-encephalogram was normal. Chest X-ray examination showed a calcified tuberculous focus in the left lower lobe.

5. A.L. (European male), aged 34 years

This patient was first admitted to a medical ward on 6 January 1960 and was quite incapable of giving any account of himself. His wife was not very informative but said that her husband had suffered from epileptic seizures 'for some years'. Two days before admission he began to have about 4 seizures a day and since then had been confused.

On admission he was confused. His general condition was poor and he had marked palmar erythema. Both feet were cold and red. He had no cranial-nerve defect and particularly no dysarthria. In the upper limbs the finger-nose test was passably well performed but rapidly alternating movements were poorly performed. In the lower limbs power was normal, but neither knee nor ankle jerks could be obtained and the calf muscles were tender. In addition there was moderate heel-knee ataxia and gross ataxia on walking so that he was unable to walk without support.

When re-examined in July 1960, there was no real change in his condition. It was then apparent that he had gross intellectual deterioration. In addition a tremor was seen involving the upper limbs (right more than left), consisting of a rapid distal pronation-supination movement at rest, resembling a Parkinsonian tremor. Serum proteins, liver-function tests and cerebrospinal fluid were normal.

6. K.A. (Coloured male), aged 35 years

This patient was admitted to a medical ward in May 1960. He was unable to give any account of himself — he was

confused and disorientated, and had gross memory loss.

His cranial nerves and upper limbs were normal. He had a mild peripheral neuritis (knee and ankle jerks barely obtainable, calf muscles tender and soles hyperaesthetic) with gross heel-knee ataxia. He was unable to walk without support.

DISCUSSION

These 6 patients (2 of whom — N.S. and E.S. — were women) were between the ages of 34 and 58 years. All were known to be severely alcoholic. The only time this was questioned was in the case of E.S., the African female, who admitted consuming large amounts of home-brewed beer. This is usually regarded as having a low alcohol content unless adulterated. Four of the patients had been drinking shortly before their admission to hospital but N.S. had been hospitalized, and was thus presumably without alcohol, for 6 months before admission; and the wife of A.L. stated that he had not had anything to drink for several months because he felt too ill.

All the patients were in fairly good general condition and looked well-nourished. Two (W.E. and C.D.), had enlarged firm livers, but all special investigations, e.g. liver-function tests, serum proteins, etc. were normal.

All patients had normal chest X-rays and no evidence of malignant disease.

All the patients had other neurological involvement in addition to cerebellar degeneration. All had evidence of peripheral nerve disease; A.L. and K.A. were grossly confused, had memory loss, and could not give any account of themselves; while N.S. had a remarkable and gross defect of memory extending back for several years, but no other evidence of intellectual deterioration. The cerebrospinal fluid was normal in 5 of the cases in whom it was examined.

Electro-encephalograms were performed in 2 patients — E.S., in whom it was normal, and N.S., where it was reported as showing generally low voltage with irregular fast frequencies and some random slow α-activity.

The cerebellar signs gave a picture, in 5 patients, conforming closely to the cases reported by Victor *et al.*[1] All 5 patients were grossly ataxic and had marked heel-knee ataxia. In 3 cases (W.E., E.S. and K.A.) this was the only clinical evidence of cerebellar defect. C.D. had mild incoordination of the upper limbs and slight dysarthria, while A.L. had difficulty in performing rapidly alternating movements with the upper limbs though the finger-nose test was normal in his case. Therefore, like the cases of Victor *et al.*,[1] there was gross involvement of the lower limbs with minimal or no upper limb defect. One patient, N.S., was unusual in that she had fairly marked dysarthria and marked ataxia and tremor in the finger-nose test, but in the lower limbs, despite gross ataxia, there was no heel-knee ataxia and toe-object testing was normal. Only one patient, W.E., showed any clinical improvement of the cerebellar signs. The other patients, despite weeks or even months of hospitalization with intensive vitamin therapy and physiotherapy, were eventually discharged essentially unchanged. In 2 cases (N.S. and A.L.), there was a tremor similar to that seen in basal ganglion disease which could not be explained by cerebellar cortical degeneration. The precise pathogenesis of the cerebellar degeneration remains a mystery.

SUMMARY

The clinical picture of chronic cerebellar degeneration in 6 chronic alcoholic patients is described in detail.

My thanks are due to Dr. S. Berman, not only for permission to publish some of his cases, but also for his invaluable clinical opinion and the reports on the electro-encephalographs.

REFERENCE

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MADNESS IN SHAKESPEARE*

THEODORE JAMES, *Chairman, Northern Areas Division, Cape Western Branch (M.A.S.A.), 1960*

For some time now I have waited for an 'excuse' to read all Shakespeare's plays, and my election to the office of Chairman of this Division and my duty to deliver a valedictory address provided me with the appropriate reason. I have attended the performance by very good companies of a number of Shakespeare's plays, but, as you know, certain of his plays are rarely performed and, as is the way of Shakespeare, he scatters his verbal gems. To appreciate their lustre fully it is therefore necessary to read all his plays and hear them in their contextual setting.

Another reason why I decided to read all Shakespeare's plays arose from my professional and academic curiosity about the number and range of Shakespeare's medical allusions. I did not realize that there was such a large number of allusions of a medical nature. After I had culled them all, however, I realized that there is much of medicine in Shakespeare — so much indeed, that it is hardly possible to do justice to this subject in an address of this kind. I, therefore, decided to refer only to the allusions to madness.

In endeavouring to systematize Shakespeare's observations on madness, I have divided them into those having a bearing on aetiology, symptomatology, and treatment.

AETIOLOGY

Shylock, in the courtroom, tells the Duke why he will insist upon the forfeit of flesh, and compares his humour with that of 'Some that are mad if they behold a cat' and

> 'As there is no firm reason to be render'd
> Why he cannot abide a gaping pig;
> Why he, a harmless necessary cat;'

Shylock therefore failed to give a reason.

The Abbess, in the *Comedy of Errors*, asks of Adriana

> 'How long hath this possession held the man?'

and then,

* Valedictory address, Bellville, Cape, 24 November 1960.

'Hath he not lost much wealth by wreck at sea?
Buried some dear friend? Hath not else his eye
Stray'd his affection in unlawful love? . . .
Which of these sorrows is he subject to?'

And when Adriana answers that she had taken her husband to task for allowing his eye to stray, the Abbess retorts,

'And thereof came it that the man was mad:
The venom clamours of a jealous woman
Poison more deadly than a mad dog's tooth.
It seems his sleeps were hindered by thy railing:
And therefore comes it that his head is light.
Thou say'st his meat was sauc'd with thy upbraidings:
Unquiet meals make ill digestions,
Thereof the raging fire of fever bred;
And what's a fever but a fit of madness?
Thou say'st his sports were hinder'd by thy brawls:
Sweet recreation barr'd, what doth ensue
But moody and dull melancholy, —
Kinsman to grim and comfortless despair, —
And, at her heels, a huge infectious troop
Of pale distemperatures and foes to life?
In food, in sport, and life-preserving rest
To be disturb'd would mad or man or beast:
The consequence is, then, thy jealous fits
Have scar'd thy husband from the use of's wits'.

And there you have the Abbess' reasoned cause and diagnosis.

In *The Life and Death of King Richard III*, the Marquis of Dorset commands 'Dispute not with her, — she is lunatic'. The word lunatic about that time implied an intermittent form of insanity occasioned by the changes of the moon.

Cardinal Campeius asks of Cardinal Wolsey, in *King Henry VIII*, whether a Doctor Pace has been replaced by the King's new favourite, and when he hears it has been so, says

'They will not stick to say you envied him;
And fearing he would rise, he was so virtuous,
Kept him a foreign man still; which so griev'd him
That he ran mad and died'.

So there we have it that grief will drive a man mad.

Grief also plays its part where Cymbeline, in the play of that name, exclaims,

'Again; and bring me word how 'tis with her.
A fever with the absence of her son;
A madness, of which her life's in danger, — . . .'

Fear, too, may be a cause of madness. Tamora, the Queen of the Goths, in *Titus Andronicus*, when she gives her children the reason for her pale looks, describes her fearful surroundings in these words:

'A barren detested vale you see it is;
The trees, though summer, yet forlorn and lean,
O'ercome with moss and baleful mistletoe:
Here never shines the sun; here nothing breeds,
Unless the nightly owl or fatal raven:
And when they show'd me this abhorred pit
They told me, here at dead time of the night
A thousand fiends, a thousand hissing snakes,
Ten thousand swelling toads, as many urchins,
Would make such fearful and confused cries
As any mortal body hearing it
Should straight fall mad or else die suddenly'.

In *King Lear*, the Earl of Gloster, remarking upon the state of the King's mind, says

'Thou say'st the king grows mad; I'll tell thee,
I am almost mad myself; I had a son,
Now outlaw'd from my blood; he sought my life
But lately, very late: I lov'd him, friend, —
No father his son dearer: true to tell thee,
The grief hath craz'd my wits. — '

You will also recall the fearful thoughts that come upon Juliet when she screws up courage to swallow the potent sleeping draught.

'Alack, alack, is it not like that I,
So early waking, — what with loathsome smells,
And shrieks like mandrakes' torn out of the earth,
That living mortals, hearing them, run mad; —
O, if I wake, shall I not be distraught,
Environed with all these hideous fears?
And madly play with my forefathers' joints?
And pluck the mangled Tybalt from his shroud?
And, in this rage, with some great kinsman's bone,
As with a club, dash out my desperate brains? — '

Banquo in the tragedy of *Macbeth*, in his wonder at the unreal nature of things about him and Macbeth, asks

'Were such things here as we do speak about?
Or have we eaten on the insane root
That takes the reason prisoner?'

I have not yet been able to discover the exact botanical nature of the plant whose root had such repute.

The Lord Chamberlain Polonius in *Hamlet* thus describes the origin of the madness he attributes to Hamlet:

'And he, repulsed, — a short tale to make, —
Fell into a sadness; then into a fast;
Thence to a watch; thence into a weakness;
Thence to a lightness; and by this declension,
Into the madness wherein now he raves'.

Polonius is very sure of this cause for Hamlet's madness which he has diagnosed, for when the king asks his queen whether she thinks this could be so, and she replies it could be very likely, Polonius feeling his diagnosis called into question, blurts out

'Hath there been such a time, — I'd fain know that, —
That I have positively said, *'Tis so*,
When it prov'd otherwise?'

And he offers his head if he proved wrong. But there is no need to accept that offer.

Lastly, we return to the culpable moon again. Othello, when advised by Emilia, Iago's wife, that a murder has been committed, declares;

'It is the very error of the moon;
She comes more nearer earth than she was wont,
And makes men mad'.

These, then, are the aetiological factors to which Shakespeare refers: love, grief, fear, jealousy, roots, the moon, and . . . cats.

SYMPTOMATOLOGY

Running seems to be a common sign of madness, and I suppose the faster the afflicted person runs the madder he is. In *Much Ado About Nothing*, the niece of the Governor of Messina, Beatrice, exclaims: 'O Lord! he will hang upon him like a disease: he is sooner caught than the pestilence, and the taker runs presently mad'. Leonato, the Governor, a few seconds later, says: 'You will never run mad, niece', and she agrees, 'No, not till a hot January'. This was, or is, possibly another form of English madness, many of us here in the South get pretty mad in the month of January.

I have already quoted Juliet's words describing her fears of the tomb and the mandrake's cries that make mortals hearing them run mad. Thersites, that pandering rogue in *Troilus and Cressida*, says of the departing Achilles and Patroclus, 'With too much blood and too little brain these two may run mad; . . .'.

In *The Tempest*, Ariel, describing the wreck to his master Propsero, says,

> 'Not a soul,
> But felt a fever of the mad, . . .'.

And Hamlet, expostulating with his mother, who alleges he is 'not all there', cries out:

> 'Ecstacy!
> My pulse, as yours, doth temperately keep time,
> And makes as healthful music: it is not madness
> That I have utter'd: bring me to the test,
> And I the matter will re-word; which madness
> Would gambol from'.

Was this an orthodox test for some kind of madness in those far-off days?

Freakish behaviour may be a manifestation of mere eccentricity, but it may be of a degree to warrant a diagnosis of lunacy and so, by this yardstick, eccentricity is closely related to lunacy. Pauline says to Emilia, a lady attending the queen in *The Winter's Tale:*

> 'I dare be sworn:—
> These dangerous unsafe lunes i' the king, beshrew
> [them!'

Saturninus, in *Titus Andronicus*, openly states that the behaviour of Titus is only feigned madness which he describes as follows:

> '. . . And what an if
> His sorrows have so overwhelm'd his wits,
> Shall we be thus afflicted in his freaks,
> His fits, his frenzy, and his bitterness?
> And now he writes to heaven for his redress:
> See, here's to Jove, and this to Mercury;
> This to Apollo; this to the god of war;—
> Sweet scrolls to fly about the streets of Rome!'

Another pattern of insane behaviour is the one adopted by Edgar in *King Lear* to protect himself from his enemies.

> '. . . : my face I'll grime with filth
> Blanket my loins; elf all my hair in knots;
> And with presented nakedness outface
> The winds and persecutions of the sky.
> The country gives me proof and precedent
> Of Bedlam beggars, who, with roaring voices,
> Strike in their numb'd and mortified bare arms
> Pins, wooden pricks, nails, sprigs of rosemary;
> And with this horrible object, from low farms,
> Poor pelting villages, sheep-cotes, and mills,
> Sometime with lunatic bans, sometime with prayers,
> Enforce their charity'.

In much more jocular mood the Fool that Edgar meets gives some simple definitions for madman: 'He's mad that trusts in the tameness of a wolf, a horse's health, a boy's love, or a whore's oath'.

Ophelia's behaviour in *Hamlet* is described by Laertes, her brother, as 'A document in madness,—thoughts and remembrance fitted' when he observes Ophelia so strangely garbed and uttering strange thoughts:

> 'They bore him barefac'd on the bier;
> Hey no nonny, nonny, hey nonny;
> And on his grave rain'd many a tear,—
> Fare you well my dove!'

'You must sing *Down a-down, an you call him a-down-a*. O, how the wheel becomes it! It is the false steward, that stole his master's daughter.'

'There's rosemary, that's for remembrance; pray, love, remember: and there is pansies that's for thoughts'.

'There's fennel for you, and columbines:—there's rue for you; and here's some for me:—we may call it herb-grace o'Sundays:—O you must wear your rue with a difference.—There's a daisy:—I would give you some violets, but they withered all when my father died:—they say, he made a good end,—'

'For bonny sweet Robin is all my joy,—' she sings again and at the end of her song leaves with the words 'And of all Christian souls, I pray God,—God b' wi' ye'. That is a rather well-known picture of a deranged mind as Shakespeare saw or imagined it.

Polonius discussing the changed behaviour of Hamlet with the king and queen said:

> 'I will be brief:—your noble son is mad:
> Mad call I it; for to define true madness,
> What is't but to be nothing else but mad?'

Whereupon the queen reproves him by asking for 'more matter with less art'. Whereupon Polonius assures the queen that he uses 'no art at all' and goes on to show that it has been Hamlet's unrequited love that has made him so. Later Polonius comments to himself 'How pregnant sometimes his replies are! a happiness that often madness hits on, which reason and sanity could not so prosperously be delivered of'.

TREATMENT

The treatment of madness in Shakespeare's day was a comparatively simple matter. Perhaps it was only the running type or frenzied type that was treated at all, for the safety of the public. In *Twelfth Night*, Sir Toby Belch, referring to Malvolio, says, 'Come, we'll have him in a dark room and bound'. Leonato, in *Much Ado About*

Nothing, deplores the habit of people so ready to give advice to those suffering under some load or other,

'... for, brother, men
Can counsel and speak comfort to that grief
Which they themselves not feel; but, tasting it,
Their counsel turns to passion, which before
Would give preceptial medicine to rage,
Fetter strong madness in a silken thread,
Charm ache with air and agony with words:'

In *As You Like It*, Rosalind in word-play with Orlando says, 'Love is merely a madness; and, I tell you, deserves as well a dark house and a whip as madmen do:'

Again, when the Abbess, in the *Comedy of Errors*, asks Adriana what she has come for, Adriana replies,

'To fetch my poor distracted husband hence:
Let us come in, that we may bind him fast,
And bear him home for his recovery'.

The Abbess later objects,

'Be patient; for I will not let him stir
Till I have used the approved means I have,
With wholesome syrups, drugs, and holy prayers.
To make him a formal man again'.

Benvolio, amazed at Romeo's melancholy, exclaims 'Why Romeo, art thou mad?' to which Romeo retorts, 'Not mad, but bound more than a madman is,'.

However, there are two rather interesting passages in Shakespeare which are tantamount to hypnotherapy and psychotherapy for the unhinged mind. King Lear is asleep on a bed in the French camp. A physician is in attendance. He has prescribed the playing of soft music. Cordelia asks the physician, '—How does the king?'. He replies, 'Madam, sleeps still'. . . . .

'So please your majesty
That we may wake the king: he hath slept long'.

She:

'Be govern'd by your knowledge, and proceed
I' the sway of your own will. Is he array'd?'

She is answered,

'Ay, madam; in the heaviness of sleep
We put fresh garments on him'.

The physician again says

'Be by, good madam, when we do awake him;
I doubt not of his temperance, . . .
Please you, draw near.—Louder the music there!'

Then a little later the physician thinks it fit that the first to speak to the waking king should be his daughter. But the king waking thinks himself dead whereupon the physician advises, 'He's scarce awake: let him alone awhile'. When question and answer follow quickly between father and daughter, the physician kindly, but firmly, advises once more,

'Be comforted, good madam: the great rage,
You see, is kill'd in him: and yet it is danger
To make him even o'er the time which he has lost.
Desire him to go in; trouble him no more
Till further settling'.

The second passage is the one in which Macbeth, enquiring after Lady Macbeth, questions the doctor. 'How does your patient, doctor?' The doctor answers,

'Not so sick, my lord,
As she is troubled with thick-coming fancies,
That keep her from her rest'.

Macbeth says

'Cure her of that:
Canst thou not minister to a mind diseas'd;
Pluck from the memory a rooted sorrow;
Raze out the written troubles of the brain;
And with some sweet oblivious antidote
Cleanse the stuff'd bosom of that perilous stuff
Which weighs upon the heart?'

To which question the doctor replies,

'Therein the patient
Must minister to himself,'

and Macbeth's riposte, 'Throw physic to the dogs,—I'll none of it.—'.

And so I come to the end of this address. I have touched upon only some of the medical allusions which I have culled from the plays of Shakespeare and from these I have selected those which have some bearing upon the mental malady of madness with the connotations attributed to this word in those times.

ANNUAL GENERAL MEETING, SOUTH AFRICAN NATIONAL COUNCIL FOR MENTAL HEALTH*

OPENING ADDRESS

B. MAULE CLARK, *Secretary for Health*

It is an honour for me to be here today to speak to this distinguished annual gathering of the South African National Council for Mental Health. I have a very high regard for this national body and for its activities and therefore it is a privilege for me to do what little I can, in my capacity as Secretary for Health, to help this organization in its splendid work.

When I say this, I am not merely being polite or flattering—I regard the work of the National Council for Mental Health and of its affiliated societies throughout the country as being of the greatest importance and benefit to the community as a whole and to our mental health services in particular.

When I was asked to address this meeting some weeks ago I felt honoured and gratified that I had been approached—at the same time, knowing that there would be many psychiatrists and others highly trained and specialized in the field of mental health, it was with some trepidation that I accepted the invitation, because I, myself, am not a psychiatrist nor have

* Held in Johannesburg on 6 and 7 October 1960.

I any specialized training in the field of mental health other than that of the ordinary medical man and public-health officer.

My interest in health is a very broad one — covering the whole field of health (both physical and mental) in all its various aspects — hygiene and the prevention and control of infectious diseases, including poliomyelitis, malaria, tuberculosis, and leprosy, among many others; maternal and child welfare; nutrition and the building of a healthy nation; and finally, mental health. I do regard mental health as one of the most important aspects of public health as we understand it to-day, and therefore I hope that those of you who are more specialized in this field than I am, will bear with me in what I have to say — much or all of which will no doubt be well known to you.

World Mental Health Year

The year 1960 was chosen some time ago by the World Federation for Mental Health — with which this organization is associated — as World Mental Health Year, and particular attention is being given to the subject of mental health by the members of this Federation throughout the world.

The World Federation for Mental Health is an international, non-governmental, organization in official relationship with the World Health Organization. It consists of professional and mental health societies in approximately 45 countries throughout the world. Here I may just digress for a moment to say that I have on more than one occasion had the privilege of hearing the distinguished director of the World Federation for Mental Health, my good friend Dr. Rees, who no doubt is also well known to many of you, address committees of the World Health Assembly at Geneva on the subject, which has been well supported by the World Health Organization. I should also like to mention here in passing that the first Director-General of the World Health Organization, a Canadian, Dr. Brock Chisholm, was himself a psychiatrist.

The World Federation for Mental Health was started about 12 years ago and during that time it has assisted and encouraged the extension of mental health work throughout the world — both in those countries where there are member associations and in others where there is no formal link with the World Federation for Mental Health. Considerable progress has been made during this period.

The purpose of World Mental Health Year is to give added stimulus to all activities in the sphere of mental health and thus, through bringing about a higher standard of mental health in general, to help lay the foundation for the long-term goal of the Federation — the promotion of harmonious human relations among all peoples.

Geestesgesondheidswerk

In die verlede, veral met die oog op die geweldige probleme wat alreeds vir baie jare ontstaan het, soos die beheer van aansteeklike siektes, probleme van moeder-en-kinderwelsyn, voedingsvraagstukke, ens., was gesondheidsbeamptes en gesondheids-administrateurs geneig om maar 'n betreklik lae voorkeur aan geestesgesondheidswerk te gee. Hulle was eintlik te besig met die beheer van fisiese siektes, wat dringende probleme geskep het, om genoeg tyd aan geestesgesondheid te bestee.

Onlangs egter, het dit al hoe duideliker geword dat die industriële ontwikkeling en die meegaande veranderings in die samelewing wat in die afgelope jare plaasgevind het, tot spanning en emosionele versteurings aanleiding gegee het, en dikwels tot ontwrigting in die gesinslewe, met die gevolg dat sielkundige en sosiale versteurings kan plaasvind. Hierdie proses vind plaas selfs wanneer die industriële ontwikkeling gepaard gaan met verbeterings in lewensstandaarde en beter algemene fisiese toestande, soos beter gesondheid, voeding, ens.

Dit het ongetwyfeld ook in ons eie land gebeur. Veral met die industriële revolusie wat in die afgelope 30 of 40 jaar hier plaasgevind het — en wat sedert die oorlog 'n veel sneller tempo aangeneem het — is daar 'n toestroming van mense na die groot stede vanuit die platteland. Die ontwikkeling van industriële en stedelike omstandighede — met die gepaardgaande ontwrigting van die familie en die gesinslewe — het sosiale en sielkundige gevare ingehou.

As gevolg van hierdie ontwikkelings word dit vandag al hoe meer besef dat daadwerklike stappe gedoen moet word om hierdie probleme die hoof te bied. Dit is noodsaaklik dat positiewe stappe gedoen word om goeie geestesgesondheid te handhaaf, en terselfdertyd te verseker dat diegene wat alreeds tekens van geestesversteurings getoon het, die doeltreffendste behandeling op die vroegs-moontlike stadium ontvang.

Die tyd het nou aangebreek vir heroorweging van hierdie vraagstukke en indien enigsins moontlik, vir die ontwikkeling van meer professionele- en publieke belangstelling in en ondersteuning van geestesgesondheidswerk. Deur die aandag van die publiek tydens Wêreldgeestesgesondheidsjaar op die vereistes op hierdie gebied te vestig, sal hopelik ondersteuning verwek, en 'n stoot gegee word aan die werksaamhede van die Nasionale Raad en aan soortgelyke rade dwarsdeur die wêreld.

Die hoop word gekoester dat, deur middel van die soeklig wat hierdie jaar op die vraagstuk gegooi word, vordering gemaak sal word deur beter en meer doeltreffende beplanning van geestesgesondheidswerk en dat psigiaters en ander medici, administratiewe beamptes, sielkundiges, sosiale werksters, en almal wat in die werk belang stel, hul bydrae sal lewer tot die oplossing van die vraagstukke wat so algemeen is en waarmee elke land te kampe het.

Net soos die bekamping van aansteeklike siektes deeglik beplan moet word om die probleme die hoof te bied, so moet ons ook met geestesgesondheidsvraagstukke vooruit beplan. Hier is ons doelwit egter moeiliker, want hier moet ons daadwerklike stappe doen teen die sielkundige spanning wat gepaard gaan met die moeilike omstandighede, die sosiale steurnisse, en die wrywing van die moderne maatskaplike lewe.

Daar word vertrou dat hoe beter hierdie vraagstukke verstaan word hoe beter hulle die hoof gebied sal kan word — en hoe meer doeltreffend sal die verligting wees wat aan diegene wat ongelukkig alreeds slagoffers van hul omstandighede geword het, aangebied kan word.

Om hierdie doel te kan bereik het ons die belangstelling en ondersteuning van *almal* nodig, want sielkundige spanning en selfs die ligter vorms van geestesversteurings is tot 'n sekere mate nog altyd by ons — nie soos aansteeklike siektes wat slegs hier en daar of af en toe opduik nie.

Met die oog op die belangrikheid van Geestesgesondheidsjaar (1960) het Sy Edele die Minister van Gesondheid, dr. Hertzog, gedurende Februarie van hierdie jaar by geleentheid van geestesgesondheidsweek goedgunstiglik 'n baie bemoedigende boodskap oor die radio uitgesaai. Die volgende is 'n paar uittreksels uit sy boodskap:

‚Ten aanvang wil ek graag my hoë waardering uitspreek teenoor die Suid-Afrikaanse Nasionale Raad vir Geestesgesondheid vir die wonderlike en onbaatsugtige diens wat dit aan die Volk van Suid-Afrika bewys, deur om te sien na die belange van die ongelukkige geestesversteurde mense in ons midde — daardie mense wie se toestand so dikwels die gevolg is van die oorjaagde en oorspanne lewe van hierdie eeu.

‚Terselfdertyd kan ek nie nalaat om ook lof en waardering te betuig teenoor die personeel wat sulke uitstaande werk in ons sielsieke-inrigtings lewer nie.'

En later het Sy Edele die Minister met die volgende woorde afgesluit:

‚Deur verstandigheid, deur vroeë aanmelding, en deur vriendskap kan ons help om die genesing van die siekes te verhaas en om troos en lig in die lewe van hul families terug te bring. Daarom dan ook ons diepe erkentlikheid aan die Suid-Afrikaanse Nasionale Raad vir Geestesgesondheid vir hul edele bydrae in hierdie belangrike saak.'

Ek beskou hierdie Raad en sy konstituerende verenigings as die skakel tussen die Departement van Gesondheid en die publiek. Die lede van die raad en van die verskillende komitees verteenwoordig daardie deel van die publiek wat nie alleen belang stel in die geestesgesondheid van sy medemens nie, maar wat terselfdertyd in staat is om behulpsaam te wees met die bekamping van die vraagstukke waarna ek alreeds verwys het en wat ook bereid is om hul tyd op te offer om daadwerklike stappe te doen.

Hoewel die sentrale regering deur die Departement van Gesondheid, en meer spesifiek deur die Kommissaris van Geesteshigiëne, verantwoordelik is vir die verskaffing van geestesgesondheidsdienste, kan dit eenvoudig nie behartig word

nie op die manier wat verlang word en wat wenslik is sonder die samewerking van hierdie Raad en sy verenigings nie. Gelukkig is daar die nouste samewerking tussen die Departement, en die Raad en sy geestesgesondheidsverenigings, en ek hoop en vertrou dat hierdie samewerking gehandhaaf en al hoe meer opgebou sal word.

Die Raad en sy verskillende verenigings vervul 'n groot verskeidenheid van baie belangrike funksies en ek wil nie eers probeer om op hulle almal in besonderhede in te gaan nie. Die inligting word in elk geval in die jaarverslae breedvoerig uiteengesit. Ek wil egter net melding maak van 'n paar aspekte van die werk van die Raad wat vir die Departement van Gesondheid van die uiterste belang is:

Klinieke

Die klinieke wat in die meeste groot sentrums dwarsdeur die land deur die verskillende verenigings in stand gehou word, vervul 'n uiters belangrike funksie. Hier kan werklik van 'n vennootskap gepraat word, want, hoewel die klinieke deur die betrokke verenigings gestig en in stand gehou word, en die akkommodasie, en die maatskaplike werksters deur hulle voorsien en betaal word, word die psigiatriese dienste self deur die mediese personeel van die regering se sielsieke hospitale of inrigtings vir swaksinniges verskaf.

Met die oog hierop kan die klinieke beskou word as 'n uitbreiding van die psigiatriese dienste van die hospitale op 'n buite-pasiënte basis — iets wat absoluut noodsaaklik is met die oog op die moderne opvatting van psigiatriese dienste. Die vroeë diagnose en die behandeling van psigiatriese gevalle, en veral van gevalle van psigoneurose, is van die uiterste belang en die nodige fasiliteite vir hierdie vroeë diagnose kan slegs beskikbaar gestel word in buite-pasiënte afdelings of klinieke wat in al die groter sentrums gestig behoort te word.

Mental Health Clinics

In addition to providing a much needed service to the community, these out-patient clinics, run by the mental health societies, have the effect of relieving the pressure on the Department's hospitals to a very appreciable extent. I feel that much more should be done to develop and extend the system of out-patient clinic services for these patients and in this expansion the Department will certainly need your help.

Appropriate action is being taken by the Department to provide considerably more institutional accommodation and, during the last few years, a very considerable number of additional beds have been provided at different institutions, while many more are in the course of construction and still others are contemplated in the near future. Nevertheless, there is a big backlog to be overcome and the relief afforded by the clinics is of great value.

The subject of clinics and the question of services outside the Departmental hospitals immediately makes one think of the question of integration of psychiatric services with other medical services. It is strongly felt that there should be a much closer association between psychiatric medical services and the services for the physically ill.

A high proportion of patients presenting themselves for treatment, both at out-patient departments of general hospitals, which of course are maintained by the Provincial Administrations, and at doctors' consulting rooms, are suffering from ailments and conditions which are not entirely physical in their origin. Many of these patients are more psychologically than physically ill. The stresses and strains of modern life and the conflicts and psychological disturbances to which these conditions give rise, are most important elements in the causation of much ill health and of many conditions often regarded as being physical in origin. The importance of psychosomatic medicine is becoming increasingly appreciated.

The psychological elements which underlie such a large proportion of the complaints dealt with by general practitioners today make it imperative that the family doctor should be thoroughly versed in this field — in fact it has been said that a big proportion of good general practice today consists of psychosomatic medicine.

The closer integration of psychiatric medical services with the provincial hospital services, and the establishment of psychiatric out-patient clinics at the major hospitals, and of wards for psychoneurotic and for short-term psychiatric patients at more of the larger provincial hospitals, would have a very beneficial effect in many ways.

The principle of the establishment and development of such services has the approval in principle of the Central Health Services and Hospitals Coordinating Council — the statutory body established under the Public Health Act some years ago to coordinate the health and hospital activities of the Central Government and of the 4 Provincial Administrations. Wards for the treatment of this type of case have already been provided at some of the major provincial hospitals. For that we are very grateful, but it is felt that the system needs to be extended considerably on the lines which I have suggested.

In addition to filling a much needed want, as far as the patients themselves are concerned, the development of such services would materially assist in providing more adequate training facilities.

Shortage of Staff

Perhaps the greatest difficulty in providing adequate psychiatric services today is the shortage of suitably trained staff — and I refer to both medical and nursing staff. This, to some extent, is due to the fact that medical students receiving their medical education in provincial teaching hospitals do not have the opportunity of coming into daily contact with this type of patient — and so there has perhaps developed a feeling that psychiatric medicine is something apart — something different from ordinary medicine.

The development of services for psychoneuroses and for short-term psychiatric cases in the general hospitals, which are used for teaching purposes, and in their out-patient departments would, it is felt, do much to dispel this idea. It would also have the effect of ensuring that the general practitioners trained in these hospitals had a better knowledge of psychiatry — which would make them better practitioners — and it would also, no doubt, encourage more doctors to take up psychiatry as their life's work.

In addition to these advantages, it would help to provide better and more adequate facilities for the postgraduate training of psychiatrists, where there is at present a very serious bottleneck, which undoubtedly has the effect of reducing the number of doctors specializing in this field. This is a very serious problem and one which we must endeavour to overcome. The matter is at present under consideration.

While we are on the subject of staff, I have already mentioned the great difficulty that is experienced in obtaining adequate nursing staff for the Departmental hospitals. Here, too, the establishment and development of these services at major provincial hospitals might have the effect of attracting more prospective nurses to this type of work and so relieving the shortage to some extent. This is a most urgent need — and the Department will be most grateful for anything this Council or its constituent societies can do to interest and encourage the right type of young man or woman to take up nursing of the mentally ill — and so give service in this most important field.

Dagwerksentrums

Nog 'n baie belangrike aspek van die werk van die geestesgesondheidsverenigings is die dagwerksentrums. Hierdie sentrums is alreeds in baie van die grotere stede gestig, maar baie meer van hulle is nodig, en die uitstekende diens wat deur hulle gelewer word behoort aansienlik verder uitgebrei te word.

Dit is baie moeilik — haas onmoontlik — om die juiste omvang van die probleem van swaksinnigheid noukeurig te bepaal, maar dit is ongetwyfeld 'n baie ernstige en algemene vraagstuk wat daadwerklike optrede verg.

Die dagwerksentrums maak voorsiening vir onopvoedbare swaksinnige kinders gedurende die dag. Daar word die kinders veilig gelaat in die sorg van simpatieke mense, soms onderwysers of onderwyseresse, wat hulle vir die spesiale taak bekwaam het.

Hoewel hierdie kinders onopvoedbaar is, kan baie van hulle tot 'n sekere mate opgelei word — veral wat betref die gewone huishoudelike take en hoe om hulle te gedra — met die gevolg dat baie van hulle aansienlike vordering maak en minder afhanklik van hul ouers word. Party van hulle is van die

dagwerksentrums in beskutte arbeid-ondernemings oorgeplaas en enkele van hulle het selfs sover gevorder dat hulle in die ope arbeidsmark geplaas is.

Afgesien van die uitstekende uitwerking op die kind self het hierdie dagwerksentrums 'n baie waardevolle sosiale funksie. As dit enigsins moontlik is wil ouers van kinders wat swaksinnig is hulle gewoonlik by die huis hou. Die liefde van 'n ouer vir sy kind — en veral vir daardie kind wat meer afhanklik is as die normale kind — laat hulle voel dat hulle die kind by die huis wil hou as hulle dit enigsins kan doen. Dit is net menslik en heeltemal reg.

Maar die gevolg is natuurlik dat daardie arme kind 'n baie stremmende uitwerking op die huisgesin het — veral as daar ander kinders is of as die moeder moet uitgaan om te werk — met die gevolg dat dit haas onmoontlik vir die ouers mag word tensy verligting verskaf kan word. En dit is juis daardie verligting vir die moeder wat deur die dagwerksentrum tydens werksure verskaf word. Dus, hoewel die kind nog in die huisgesin bly, kan die moeder tog 'n kans kry om haar huiswerk te doen, die ander kinders te versorg of, waar dit nodig is, om uit te gaan na haar werk.

Daarby kom die feit dat die dagwerksentrums 'n mate van verligting gee, teen baie geringe onkoste, aan die tekort aan akkommodasie in ons inrigtings vir swaksinniges. Dit sou 'n geweldige taak wees om inrigtingsakkommodasie vir alle swaksinniges te verskaf — en onder al die omstandighede is dit nie wenslik om dit te probeer doen nie. Myns insiens behoort baie meer van die dagwerksentrums gestig te word. Dit is 'n verstandige, menslike, en ekonomiese manier om hierdie ernstige en moeilike vraagstuk die hoof te bied, en die stelsel van dagwerksentrums behoort baie uitgebrei te word.

Jeugmisdaad

Ek wil hier graag 'n paar woorde sê oor die behoeftes van die kind in die algemeen en die daarbygaande ernstige probleem van jeugmisdaad.

'n Sekere persentasie van kinders verg spesiale aandag, òf om gedragsafwykings in die vroegs moontlike stadium te bespeur en hul ontwikkeling te voorkom, òf, waar sulke gedragsafwykings alreeds 'n ernstige stadium bereik het, om sielkundige of psigiatriese behandeling beskikbaar te stel.

Jeugmisdaad, wat vandag ernstige afmetings aanneem, word gewoonlik òf met onbevredigende huislike omstandighede, òf met 'n mate van verstandelike subnormaliteit geassosieer. Albei kan aanleiding gee tot wanaanpassings wat, tensy hulle op 'n vroeë stadium bespeur en verbeter word, tot slegte geestesgewoontes en gedragspatrone kan lei. Tensy vroeë stappe gedoen word om hierdie ongunstige ontwikkelings die hoof te bied, kan hulle later aanleiding gee tot jeugmisdaad met al sy ernstige gevolge.

Ten einde die probleem van jeugmisdaad te bekamp, is dit noodsaaklik dat die nodige maatreëls getref word om by sulke gevalle gunstiger huislike omstandighede te skep en, waar nodig, om spesiale onderwysfasiliteite beskikbaar te stel.

The Credit Side

From what I have said this evening it is evident that there is a tremendous amount to be done in the field of mental health in the Union. That is so of course, but let us not strike too pessimistic a note. If we look back a few years we shall realize that there is also much on the credit side — that much has been achieved.

Firstly, there is the question of increased accommodation in our mental hospitals. There is of course still a great need for more accommodation for certain categories of patients, but the position has improved greatly since 5 years ago when I served on a small committee of enquiry which investigated this matter. A great deal has been done to relieve the position since then and much more is being done.

Apart from the fact that more accommodation has been provided, another factor that has relieved the position greatly in recent years is the more effective treatment of cases which is now available. This has had the result that many more patients are able to leave hospital after a relatively short period of treatment.

This is a very encouraging development and will, I hope, help to make the public realize that mental illness, like physical illness, can be cured and should be detected and treated early for the best results. It is no exaggeration to say that the whole outlook for most of these cases has altered greatly for the better in the last few years.

In addition to these encouraging developments, we also find that the shortage of doctors to fill posts in our mental health services is not nearly as acute as it was a few years ago. Whereas a few years ago there were many posts vacant, today nearly all the medical posts in our mental hospitals and in our institutions for the feeble-minded are filled. The position a few days ago was that of 71 medical posts, 10 were not filled by either permanent or temporary incumbents. And, for these 10 vacancies, 4 candidates had been nominated for permanent appointment but had not yet assumed duty. Thus, when these 4 medical officers assume duty, there will only be 6 actual vacancies.

The improvement in this connection is partly attributable to the improved salaries paid to medical officers in the public service. The salary scales are now very attractive, particularly for young doctors who have qualified recently.

In addition to this, the system recently introduced of awarding bursaries to senior medical students to assist them in their studies, with the provision that they will serve the Government for a certain period after qualification, will, it is hoped, materially help to interest younger medical men in careers in our service. So that, altogether, the position regarding medical staff is much brighter than it was a few years ago.

I do not want to create an atmosphere of complacency — and I myself am very far from complacent because I realize what an enormous task lies ahead of us, but we must go forward with courage and determination.

Slot

Ter afsluiting wil ek weer eens beklemtoon dat myns insiens die Nasionale Raad vir Geestesgesondheid en sy konstituerende verenigings 'n uiters belangrike rol speel. Die verenigings vervul die funksie van 'n buite-pasiënte afdeling vir die Departement. Afgesien van die psigiatriese dienste, wat deur die Departement se medici verskaf word, doen die personeel van die verenigings die voorbereidingswerk vir die psigiaters — wat absoluut noodsaaklik is. Daarby doen hulle die nasorgwerk van ontslane sielsieke pasiënte. Hierdie nasorgwerk is besonder goed en daar bestaan 'n hartlike samewerking tussen die geestesgesondheidsverenigings en die hospitale van die Departement.

Ek is daarvan oortuig dat die Raad en sy verenigings met vooruitstrewende doelstellings besiel is. Noue samewerking tussen die Raad en die Departement is van die uiterste belang en ek persoonlik sal alles in my vermoë doen om dit aan te moedig en op te bou.

I wish the National Council for Mental Health, and all the mental health societies which are affiliated with it, every success in their splendid work.

BRITISH MEDICAL ASSOCIATION

DORIS ODLUM PRIZE, 1962

The Doris Odlum Prize (1962) for studies in the field of Mental Health will be awarded in 1962 for a study of 'Progress in the community care of mental disorder' (a critical and constructive review of advances made in this field in the 5 years ending on 30 September 1961).

The value of the prize is £80 and any medical practitioner registered in the British Commonwealth or in the Republic of Ireland may compete.

Preliminary notice of entry is required, and forms and further particulars may be obtained from the Secretary, British Medical Association, BMA House, Tavistock Square, London, W.C.1.

The closing date for entries is 31 December 1961.

OFFICIAL ANNOUNCEMENT : AMPTELIKE AANKONDIGING

SOUTH AFRICAN MUTUAL MEDICAL AID SOCIETY

Following on announcements which have already appeared in the *Journal* we repeat for the information of members of the Association that all negotiations with the South African Mutual Medical Aid Society have been broken off. In addition the approval granted to certain groups (whose names were published in the *Journal* of 10 December 1960) was also withdrawn.

The reasons for the break, as explained in previous announcements, were the establishment by the Society of an unacceptable medical aid scheme into which the Society intended to transfer all its insured members. In addition the Society refused to cease issuing cheques made out according to the preferential tariff and tendering them to doctors with the intention that they should accept these 'coded cheques' *in full settlement* of accounts which were rendered according to the fees for private patients. This is a form of pressure being brought to bear on medical practitioners with which the Association could not agree.

By this time members will have received the circular which has been sent to all members of the Association and which explains the whole matter. In the circular members are advised to inform their patients who are members of the South African Mutual Medical Aid Society that they will be treated as ordinary patients from whom fees will be claimed and who should make their own arrangements regarding indemnity with the Society. Members of the Association are also requested to inform the South African Mutual Medical Aid Society that they do not wish to receive any cheques from the Society but that they will look to their patients for payment. Members are respectfully urged to accede to this request and to make use of the slips at the foot of the circular. If any member has not received a circular he should inform the Secretary of the Association, P.O. Box 643, Cape Town, of the fact.

The attention of members is again drawn to the request which the Editor of the *Journal* made in his editorial: 'Negotiations with medical aid societies and insurance companies' which appeared in the *Journal* for 28 January 1961, viz., that members should not make personal arrangements with insurance companies. Such arrangements may appear advantageous to practitioners but quite possibly do not agree with the policy of the Association. Personal arrangements lead to disintegration and hamper the work of negotiating Committees of the Association. Members are requested to discuss their problems or proposals at meetings of their Branches or write to the Head Office of the Association in this connection so that the Association may act in concert and uniformity.

L. M. Marchand
Associate Secretary

28 Plaza Building
Bank Lane
Pretoria
15 February 1961

SUID-AFRIKAANSE ONDERLINGE MEDIESE HULPVERENIGING

In opvolging van aankondigings wat alreeds in die *Tydskrif* verskyn het, wil ons net weer vir die inligting van lede van die Vereniging herhaal dat alle onderhandelinge met die Suid-Afrikaanse Onderlinge Mediese Hulpvereniging afgebreek is. Die goedkeuring wat aan sekere groepe (waarvan die name in die *Tydskrif* van 10 Desember 1960 verskyn het) verleen is, is ook teruggetrek.

Die redes vir hierdie breuk wat ook in die vorige aankondigings uiteengesit is, kom daarop neer dat die Hulpvereniging 'n onaanneemlike mediese hulpskema opgerig het waarin dit die plan is om al sy versekerde lede op te neem. Daarbenewens wou die Hulpvereniging nie afsien van sy voorneme om tjeks wat volgens die voorkeurtarief uitgemaak is aan dokters aan te bied nie met die verwagting dat dokters hierdie tjeks (die sogenaamde ‚coded cheques') moet aanneem *ter volle vereffening* van rekenings wat volgens die gelde vir private pasiënte gelewer is. Dit is 'n vorm van druk wat op die geneeshere uitgeoefen word waarmee die Vereniging nie kan saamstem nie.

Teen hierdie tyd het lede al seker die omsendbrief wat aan alle lede van die Vereniging gestuur is, en wat die hele saak uitlê, ontvang. Daarin word aan die hand gedoen dat lede van die Vereniging hul pasiënte wat lede van die Suid-Afrikaanse Onderlinge Mediese Hulpvereniging is in kennis moet stel dat hulle as gewone pasiënte behandel sal word van wie gelde geëis sal word en wat hul eie reëlings met betrekking tot indemniteit met die Hulpvereniging moet tref. Verder word in die omsendbrief versoek dat lede van die Vereniging die Suid-Afrikaanse Onderlinge Mediese Hulpvereniging in kennis moet stel dat hulle geen tjeks van die Hulpvereniging wil ontvang nie, maar dat hulle na hul pasiënte vir betaling sal omsien. Beleefdelik word gevra dat lede aan hierdie versoek gehoor gee en van die strokies onderaan die omsendbrief gebruik maak. Indien u geen omsendbrief ontvang het nie laat asseblief die Sekretaris van die Mediese Vereniging, Posbus 643, Kaapstad, daarvan weet.

Graag wil ons weer verwys na die versoek wat die Redakteur van die *Tydskrif* in sy inleidingsartikel: ‚Onderhandelinge insake mediese hulpverenigings en versekeringsmaatskappye' in die *Tydskrif* van 28 Januarie tot lede gerig het, nl., dat lede nie persoonlike ooreenkomste met versekeringsmaatskappye moet aangaan nie. Sodanige ooreenkomste mag vir geneeshere voordelig lyk, maar heel moontlik kom hulle nie ooreen met die beleid van die Vereniging nie. Dit werk verbrokkeling in die hand en bemoeilik die werk van onderhandelende Komitees van die Vereniging. Lede word versoek om hul moeilikhede of hul voorstelle by hul Takvergaderings te bespreek of aan die Hoofkantoor van die Vereniging daaromtrent te skrywe sodat die Vereniging gesamentlik en eenvormig kan optree.

L. M. Marchand
Medesekretaris

Plaza-gebou 28
Banksteeg
Pretoria
15 Februarie 1961

WORLD LIST OF FUTURE INTERNATIONAL MEETINGS

Continued from the issue of the Journal *for 18 February 1961* (**35,** 136)

Second International Conference of Human Genetics, Rome, 7 - 12 September 1961. Prof. Luigi Gedda, President, Congress Organizing Committee, c/o Instituto Gregorio Mendel, Piazza Galeno 5, Rome, Italy.

Fifth International Congress of Electroencephalography and Clinical Neurophysiology, Rome, 7 - 13 September 1961. Dr. R. Vizioli, Secretary General, Clinica delle Malattie Nervose e Mentali, Viale Università 30, Rome, Italy. In conjunction with 7th International Neurological Congress, 10 - 17 September 1961.

International League against Epilepsy, 9th meeting, Rome, 10 September 1961. Dr. R. Vizioli, Viale dell'Università, Rome.

Sixteenth International Tuberculosis Conference, Toronto, 10 - 14 September 1961. Dr. C. W. L. Jeanes, Secretary General, 265 Elgin Street, Ottawa, Canada.

Seventh International Neurological Congress, Rome, 10 - 17 September 1961. Dr. Giovanni Alemà, Secretary-General, Viale Università 30, Rome, Italy.

International Union for the Scientific Study of Population, 12th Congress, New York, 11 - 16 September 1961. Clyde V.

Kiser, Milbank Memorial Fund, 20 Wall Street, New York 5, N.Y. The Congress in the United States will be held at the invitation of the American Population Association.

University of Hong Kong, International Scientific Congress, Hong Kong, 11 - 16 September 1961. University of Hong Kong, Hong Kong. Part of University Jubilee celebrations.

International Congress on Psychosomatic Medicine and Childbirth, Paris ?, 12 - 15 September 1961. Dr. L. Chertok, Secretary, c/o Société Française de Médecine Psychosomatique, 54 av. de la République, Villejuif (Seine), Paris, France.

Second International Symposium on Chemotherapy, Naples, 14 - 17 September 1961. Dr. P. Rentchnick, Secretary General, Case 229, Geneva 4, Switzerland.

Fifteenth General Assembly of the World Medical Association, Rio de Janiero, 15 - 20 September 1961. Secretary General, 10 Columbus Circle, New York 19, N.Y., USA.

Sixth International Congress of Neuroradiology, Rome, 18 - 22 September 1961. Dr. Enzo Valentin, General Secretary, Symposium Neuroradiologicum, CIT — Ufficio Congressi — p.Colonna 193, Rome, Italy.

Second International Congress of Neurological Sciences, Rome, 19 - 22 September 1961. Prof. Mario Gozzano, President of Congress, Via Archimède 62, Rome, Italy.

International Office of Documentation of Military Medicine, 23rd Session, Athens, 19 - 22 September 1961. International Committee of Military Medicine and Pharmacy, Hôpital Militaire, 79 rue Saint Laurent, Liège, Belgium.

International Conference on the Influence of Living and Working Conditions on Health, St. Vincent, near Turin, 29 September - 1 October 1961. Dr. F. Scholl, Burggasse 71/6, Vienna 7, Austria. International Medical Association for the Study of Living Conditions and Health.

International Atomic Energy Agency, 5th General Conference, Vienna, 26 September 1961. 11 Kärntner Ring, Vienna 1, Austria.

European Association Against Poliomyelitis, 7th Symposium, Oxford, England, September 1961. Dr. P. Recht, Secretary General, 56 rue Charles Legrelle, Brussels 4, Belgium.

European Conference of Experts on Student Mental Health, Switzerland, September 1961. World University Service, 13 rue Calvin, Geneva, Switzerland.

Sixth European Dietetic Conference, September 1961. Dr. H. Kapp, 44 Holbeinstr., Basel, Switzerland.

Fourth International Congress of Angiology, Prague, September 1961. Prof. Bohumil Prusík, President, c/o Faculty of General Medicine, Charles University, 1 Parizska Tr. 27, Prague, Czechoslovakia, International Cardiovascular Society.

Symposium on Neurochemistry, Rome, September 1961. Commission of Neurochemistry, World Federation of Neurology, 59 rue Phillippe Williot, Berchem-Antwerp, Belgium.

Third Inter-African Conference for Food and Nutrition, Bukavu, Congo Republic, 2 - 11 October 1961. Commission for Technical Cooperation in Africa South of the Sahara, Pvt. Mail Bag 2359, Lagos, Nigeria.

Fifth Latin American Congress of Electroencephalography, México, D.F., 4 - 10 October 1961. Dr. José H. Mateos, Tonalá 15, México 7, D.F., México.

Ninth Latin American Congress of Neurosurgery, México, D.F., 4 - 10 October 1961. Dr. Jose Mateos, Tonalá no. 15, México 7, D.F. México.

Council for International Organizations of Medical Sciences, General Assembly, 5th Session, 6 - 7 October 1961. CIOMS, 6 rue Franklin, Paris 16e, France.

Second International Congress of Neurological Surgery, Washington, D.C., 14 - 20 October 1961. Dr. Bronson S. Ray, Secretary General, 525 E. 68th Street, New York 21, N.Y. World Federation of Neurosurgical Societies.

Fourth International Congress of Allergology, New York, 15 - 22 October 1961. Dr. William B. Sherman, Secretary, 60 E. 58th Street, New York 22, N.Y.

Symposium on Methods of Applied Research in Higher Nervous Activity, Prague, October 1961. Prof. Dr. O. Vinar, Czechoslovak Medical Society, Juan Evangelista Purkinje, Pharmacological and Physiological Sections, Prague, Czechoslovakia.

Ciba Foundation Symposium on Transplantation, London, 1 - 3 November 1961. Ciba Foundation, 41 Portland Place, London, W.1. (By invitation.)

International Symposium on the Etiology of Myocardial Infarction, Detroit, 16 - 18 November 1961. Dr. Thomas N. James, Chairman, Section on Cardiovascular Research, Henry Ford Hospital, Detroit, Michigan, USA. (By invitation.)

Conference on the Significance of Lipids in Nutrition, Prague, November 1961. Dr. Jos. Mašek, Nutrition Research Institute, Czechoslovak Medical Society, Jan Evangelista Purkinje, Gastroenterological Section, Prague, Czechoslovakia.

PASSING EVENTS : IN DIE VERBYGAAN

Dr. H. Hamersma, keel-, neus- en oorarts, het sy adres verander van Mediese Sentrum tot Van Riebeek Mediese Gebou 622, Schoemanstraat, Pretoria, telefoon 3-3444.

* * *

Residential Services for Unmarried European Mothers. The South African National Council for Child Welfare has announced that the Princess Alice Adoption Home, which operates under the auspices of the Johannesburg Child Welfare Society, has extended its premises and the Committee is now in a position to offer accommodation to more expectant mothers than in the past. In addition to accommodation, these unfortunate girls are given care and skilled guidance through the services of specially qualified social workers and, if necessary, a qualified psychiatrist.

For information about the conditions under which expectant mothers can be received and applications for the services of the Home, direct application should be made to the Adoption Secretary, Princess Alice Home, P.O. Box 2539, Johannesburg.

* * *

South African Institute for Medical Research, Johannesburg, Staff Scientific Meeting. The next meeting will be held on Monday, 6 March at 5.10 p.m. in the Institute Lecture Theatre. Dr. A. G. Oettlé will speak on 'Cancer mortality in Whites in South Africa'.

* * *

University of Cape Town and Association of Surgeons of South Africa (M.A.S.A.), Joint Lectures. The next lecture in this series will be held on Wednesday 1 March at 5.30 p.m. in the E-floor Lecture Theatre, Groote Schuur Hospital, Observatory, Cape. Dr. A. B. Bull will lecture on 'A tour of anaesthetic centres overseas'. All members of the Medical Association are welcome to attend this lecture.

* * *

Research Forum, University of Cape Town. The next meeting will be held on Thursday 2 March at 4 p.m. in the Tutorial Room of the Pathology Department, Medical School, Observatory, Cape. Dr. W. P. U. Jackson and Dr. C. P. Dancaster will present a paper entitled 'The action of vitamin D in Man: Clinical studies'. This will be followed by a Staff Clinical Conference held in the Falconer Lecture Theatre, E-floor, Groote Schuur Hospital, Observatory, Cape, at 5.15 p.m. All general practitioners and others who may be interested are invited to attend these meetings.

* * *

South African Paediatric Association (M.A.S.A.), Natal Sub-Group. The annual general meeting for full members of this Sub-Group will be held on Monday 27 February at 6.30 p.m. at the Outspan Hotel, Durban. At 8 p.m. the same evening a general meeting for all members of the Group will be held. Mr. B. M. Pechey, Director of the Meyrick Bennett Children's Centre, will speak on 'Psychological work with children and families'.

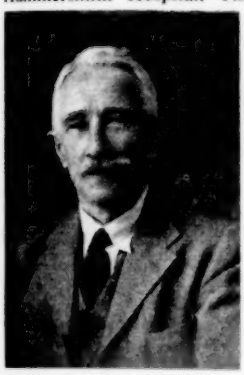
IN MEMORIAM

WILLIAM GORDON GRANT, M.D., F.R.C.O.G.

Dr. James Black, of Johannesburg, writes:

The medical profession in South Africa has lost one of its oldest and most esteemed members, and the doyen of the obstetrical and gynaecological specialists, in the passing away of Dr. William Gordon Grant, familiarly and affectionately known by his students and colleagues as 'G.G.'

He was born at Glenlivet, Banffshire, Scotland, in the year 1873. He was educated at Tombai and Chapeltown schools and later at Drainie where, it is interesting to know, one of his teachers was Ramsay MacDonald. Later he went to Elgin Academy and in 1891 he proceeded to Aberdeen University where he graduated M.B., C.M. with honours in 1895 and M.D. in 1898. Among other distinctions, he won the Shepherd Medal for Surgery and was also awarded the Thompson Travelling Fellowship and went to Germany. There he worked under Virchow, Olshausen, Winter, and Martin. At Munich University he worked under von Winkel. From Germany he went to London to the Chelsea Hospital for Women and the Hammersmith Hospital. Then he went to Paris where he worked at Bojour Hospital under Dr. Ceres, and at other hospitals in Paris.



Dr. Gordon Grant

During his sojourn in Germany and France he must have become well acquainted with the language of both countries, and I know that he also had a fair knowledge of Italian — in fact he seemed to have a special flair for languages. When he came to South Africa he also learnt the 'Taal' and I have heard him say that he possessed a moderate knowledge of Yiddish. I also remember him telling me that while he was in Nigeria he was so disgusted with the lack of proper translations from Arabic into English, and the poor interpreters supplied at inquests and enquiries, that he decided to learn Arabic himself. He did so and ultimately carried out these enquiries without an interpreter. His son tells me that he used to take pleasure in reading books in Arabic after he had retired to Botha's Hill.

I am not certain when he went to Nigeria, but it must have been before the Anglo-Boer War, for I remember him telling me that he first heard of that war having broken out when he was in Ashanti and that it had been in progress for a considerable time (I think it was months) before he heard the news, showing how long news took to travel to the wilds of Africa in those days. He must have been in the army then, for I have heard him tell me how he took part in the Ashanti and other local wars.

He was in Nigeria for about 3 years. He then came to Johannesburg in 1904 and his medical life thereafter was spent there. He was appointed gynaecologist to the Johannesburg General Hospital, and to the staff of the Queen Victoria Maternity Hospital. He was the first specialist in obstetrics and gynaecology in Johannesburg, and I am not sure if he was not the first in South Africa. It was interesting to hear him talk of those early days. I still remember him telling me that he was permitted at first to operate only *per vaginam*, but was not allowed to operate *per abdomen*!

He was appointed professor of gynaecology soon after the medical school was established in Johannesburg. At first there was also a professor of obstetrics (Professor McGibbon), but when the latter was appointed to the chair of obstetrics (and gynaecology?) at St. Andrews University, Scotland, the chairs here were combined and Professor Grant was made Professor of both obstetrics and gynaecology, a post which he held till the end of 1938 when he retired on age limit.

He had the task of building up this department in the new medical school from its inception, and he had no full-time medical staff at the beginning nor through the whole of the time of his occupancy of the chair — some 16 years. Indeed, Professor Dart, when he was Dean of the Faculty of Medicine, informed me, when I succeeded Professor Grant and asked for more accommodation, that the 3 clinical professors were not provided with any rooms in the medical school, because they said they would not require any 'since all their work would be done in the Hospital'.

In spite of this lack of full-time staff, he performed yeoman service on behalf of the University and the 2 hospitals and built up an excellent and efficient department.

I never had the opportunity and privilege of hearing him give a lecture to his students, but I understand he was a 'magnificent' teacher, clear and didactic, a method which always appeals to student-audiences. His past students still express a very high regard for him and for what he taught them. Many have good reason to thank him for the help he has given them. I and many of his younger part-time colleagues owe him a debt of gratitude for his encouragement and assistance in numerous ways.

To have watched his deftness with his favourite needle-holder was an education in itself. In many ways he showed he had the outlook of an engineer, which I have heard him say he would like to have been. He was an excellent carpenter and he made many of the fine pieces of furniture in his own home. After he retired to Botha's Hill, he taught carpentry to the boys in one of the schools in the vicinity, and continued doing carpentry work in his workshop till quite recently.

He was a Foundation Fellow of the Royal College of Obstetrians and Gynaecologists and a member of its South African Reference Committee from 1934 to 1952. I understand he also became, after his retirement, a Foundation Fellow of the College of Physicians, Surgeons and Gynaecologists of South Africa.

During World War I, he was in charge of the Wanderers' Military Hospital. In 1956 he was appointed Professor Emeritus by the University of the Witwatersrand.

He was a loyal friend, but had little time for the individual whom he considered and described as 'a danger to the public'. His former patients talk of him with great affection. Those of us who knew him well, loved him and looked upon him as the pioneer of his speciality in South Africa. He was a great personality in the medical life of Johannesburg during the 1st half of this century, and many of us feel that our medical world has not only been fortunate in being blessed with his skill and his company for so many years, but that it will be much poorer with the departure of its beloved 'G.G.'

NEW PREPARATIONS AND APPLIANCES : NUWE PREPARATE EN TOESTELLE

TRESCATYL

Maybaker (S.A.) (Pty.) Ltd. announce that Trescatyl brand ethionamide is available in containers of 50×250-mg. tablets, in addition to the pack of 250×250-mg. tablets.

The manufacturers feel that the smaller package will be more convenient for the filing of prescriptions relating to patients discharged from tuberculosis institutions, but who still require the administration of Trescatyl.

Further information may be obtained from Maybaker (S.A.) (Pty.) Ltd., P.O. Box 1130, Port Elizabeth.

CORRESPONDENCE : BRIEWERUBRIEK

WHEN A DOCTOR DIES

To the Editor: It has occurred to Dr. Harold Hofmeyr and myself that the bereaved wives and families of our dead colleagues are easily forgotten by the rest of us who are lucky enough to remain alive and well, busy doing our work and earning our living.

Of course the Benevolent Fund does its bit. Those bereaved families unfortunate enough to be in grave want, even of food and housing or essential care, are remembered because we can offer them some pittance to relieve their greatest needs. Many, each year, have to be refused any help at all.

Much more than this is required of us if we are not to hang our heads in selfish shame.

We are quick to think — when idle gossips accuse us of charging highly for our services — of all the work we do for no fees at all; we are corporately proud that the earnings of the profession as a whole show that we work harder than most for our due share of income, we try to keep our professional minds on a higher-than-material plane, and our hearts in our work and our love for our fellow man ever ready when he needs it.

Surely of all the claims on our 'Charitas', that of the bereaved families of all our dead colleagues comes first. 'Charitas' — our 'love-of-fellowmen' of which the translation is so often misunderstood and misused as 'charity'.

Let us ask a colleague's widow and family to share a meal with us occasionally, or to go with us to a concert. Perhaps we could offer them help or at least advice on such problems as school-leaving and teen-age difficulties. Perhaps we could take them on a picnic or to the circus.

Let us show our gratitude — that rarely manifested virtue — for our own health and happiness by forming a committee of doctors' wives in each Branch to receive a list of the families concerned from the Hon. Secretary, and immediately to begin acting in the manner suggested.

We are sure that great comfort and joy will be brought into the hearts and homes where now there is much loneliness of spirit.

R. D. H. Baigrie

National Mutual Buildings
Church Square
Cape Town
13 January 1961

MEMORIAL TO THE LATE DR. LOUIS MIRVISH

To the Editor: Under the chairmanship of Dr. A. Landau, and sponsored by several prominent professional and other dignitaries, an inaugural meeting was held on Tuesday 31 January 1961, in the Bennie de Wet Lecture Theatre, Groote Schuur Hospital, Cape Town, to discuss the desirability of raising funds in order to establish a fitting memorial to the late Dr. Louis Mirvish.

The meeting was well attended by many medical as well as non-medical friends of the late Dr. Mirvish, and a Board of Trustees was elected.

It was decided that the form which the Memorial would take would depend on the amount collected.

R. L. Tobias

516 Medical Centre
Heerengracht
Cape Town
7 February 1961

'N INTERESSANTE KRAAMGEVAL : PLASENTA PREVIA

Aan die Redakteur: Ek was hierdie week uitgeroep na 'n plaas waar 'n naturellevrou geboorte-moeilikheid gehad het. Toe ek die half donker stroois binnegaan, sien ek gelukkig dat die plasenta tussen haar bene lê. Op my vraag ‚Hoe is die baba?' deel hul my mee dat die baba nog nie gebore is nie.

Dit blyk toe dat sy reeds 48 uur in kraam is. Vier-en-twintig uur gelede het sy baie begin te bloei en 6 uur gelede het die plasenta uitgekom. Met ondersoek is gevind dat sy voltyds swanger was en dat die plasenta uit was, maar dat dit nog aan die naelstring vas was. Ek het toe die koord afgebind en so die plasenta van die baba geskei (L.W. Nie die baba van die plasenta nie!)

Sy is toe 60 myl ver hospitaal toe vervoer, maar is toe 12 uur later oorlede sonder dat iets aan haar gedoen kon word. Ek het die plasenta in 'n sak saamgeneem ingeval my kollegas my nie sou wou glo nie.

T. B. de Bruyn

Venterstraat 8
Steynsburg
5 Februarie 1961

BURIED SILK SUTURES IN LENS SURGERY

To the Editor: I read with interest Mr. M. H. Luntz's article[1] in the *Journal* of 28 January 1961 on the use of virgin silk in cataract surgery. These sutures were first advocated by Barraquer some 4 or more years ago and have in fact been used in Cape Town by myself and others since 1958. Nearly all ophthalmic surgeons will agree that the use of sutures after lens extraction is now almost the rule although not all will fall for the use of these very fine silk sutures which are extremely difficult to handle and a source of annoyance both to the theatre sister and the surgeon. Other forms of suture are still popular and will continue to be used.

However, it is in the use of figures to support his contention that I wish to join issue with Mr. Luntz. He has chosen to compare 2 very different series of cases in order to prove a single point. In the one instance there is a series of cataract operations done by a single surgeon — himself — using the same technique and presumably working under the same conditions. In the other he has a series of cases selected at random done in a different hospital on different types of patients by 12 different surgeons using their own techniques. The variable he wishes to compare is the suturing, yet all the other factors must necessarily render such a comparison worthless. He has indeed himself stated that 'so many other factors are involved . . . that it is impossible to be dogmatic about this'. Then why adduce these figures at all?

I have noticed a tendency in medical literature to quote figures in support of the advocacy of one or other technique or instrument, which now amounts to almost a fetish. I consider that in reality it detracts from the value of an article rather than adds to it when figures are not very carefully chosen. Mr. Luntz has succeeded in showing that in his hands the use of virgin silk has led to satisfactory results when he has used a technique that is standard for himself, while at the same time showing up the surgery at the Groote Schuur Hospital, Cape Town, in rather a poor light.

I am sure that this was not his intention at all, yet one cannot escape the inference when the number of complications, and especially hyphema, is studied. Besides, I do not think that hyphema can be related to suturing in the way which he suggests it is. I would suggest that the only reasonable comparison would be a series of cases done by the *same* surgeon, using virgin silk on each *alternate* case and any other suture on the others. This would reduce the other variables to a minimum. It is quite possible to do such a series and it may well give rewarding results.

J. G. Louw

Medical Centre
Heerengracht
Cape Town
7 February 1961